WILMINGTON GASTROENTEROLOGY ASSOCIATES, PA

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WENDY LANDRIGAN, PAC
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RHEANNA MCKNIGHT, PAC

5115 OLEANDER DRIVE WILMINGTON NC 28403
PHONE: (910) 362-1011 FAX: (910) 350-3199

FAX #: (910) 350-3199
SCHEDULERS FAX REFERRAL FORM

WGA chart #_____

Please complete this form and fax with the PATIENT'S LAST OFFICE VISITS, ALL RECENT LAB AND X-RAY RESULTS, ANY PREVIOUS COLON/EGD REPORTS and PATHOLOGY, COPIES OF INSURANCE CARDS.

****IF YOU ARE REFERRING THIS PATIENT FOR A **SCREENING COLONOSCOPY**, PLEASE BE AWARE THAT ALL INSURANCE PLANS DO NOT COVER THIS AND **PT NEEDS TO BE AT LEAST 50 YEARS OF AGE** ****

PATIENT NEEDS TO BRING INSURANCE CARDS AND LIST OF MEDICATIONS TO THEIR APPOINTMENT

Referring MD_____PH # _____ FAX#_____

MD's Mailing Address: _____NPI#_____

Sender's Name _____Date Sent to WGA: _____

Patient's Primary Care Physician: _____ PH#: _____

PATIENT'S Name_____ **Male Female** *(circle)*

DOB_____/_____/_____SSN_____-_____-_____**HM PH#**_____

ADDRESS_____ **WK PH#**_____

_____ **CELL PH#**_____

INSURANCE COMPANY: _____ ID#: _____
GROUP #: _____ INSURED EMPLOYER: _____

++++*PLEASE BE AWARE THAT WE ARE OUT OF NETWORK WITH AETNA*++++
****PLEASE CHOOSE TYPE OF APPOINTMENT NEEDED****

-Endoscopic Ultrasound (EUS) and DX: _____
-COLONOSCOPY (Screening only) :_____
-OFFICE CONSULT and DX: _____

Physician Requested_____Can your patient see 1st available Physician Assistant (circle) Y N

We have contacted your patient and scheduled this appointment:

Appointment Date: _____/_____/_____ Time: _____ AM / PM **ARRIVE AT_____**

Prep Date for procedure: _____/_____/_____ Time: _____ AM / PM **ARRIVE AT_____**

Appointment made with: _____PA-C / MD

Scheduler's Name _____ Questions, call: (910) 362-1011 Ext: _____

Please ask your patient to call us if this appointment needs to be rescheduled. A $25.00 fee will be charged if appointment is not cancelled within 24-hours ****Fax patient records to (910) 350-3199*