WILMINGTON GASTROENTEROLOGY
5115 OLEANDER DRIVE
WILMINGTON, NC 28403

REFERRAL REQUEST

FAX TO: (910) 350.3199
PHONE: (910) 362.1011

*Phone option **4** for referrals & scheduling*

REFERRING PROVIDER INFORMATION:

Provider Name: _____ Practice: _____

Date of Referral: _____ Phone: _____ Fax: _____

Senders Name: _____

Patient PCP: _____ Phone: _____

PATIENT INFORMATION:

Please send clinical data to include most recent labs, tests, office notes, pathology, medication/allergy lists & copy of insurance card.

Patient Name: _____ DOB: _____

SSN: _____ Gender: ☐Male ☐Female

Home Phone: _____ Cell Phone: _____

Home Address: _____

Primary Language: _____ Interpreter needed? ☐Yes ☐No

Insurance Carrier: _____ ID #: _____ Group #: _____

Referral Information:

Please note if your patient is experiencing GI symptoms we require and office visit prior to a procedure.

Symptoms(s)/Reason(s) for Referral: _____

Cirlce one below:

Office Visit Screening Colonoscopy Fibroscan EUS Other _____

__No provider preference __William King, MD __ Steve Klein, MD

__D. Spencer Carney, MD __Mary Sauer, MD __Kunal Dalal, MD __Justin Miller, MD

__Russell Dolan, MD

Our practice can also receive your referral requests via secure direct messaging at wilmingtongi@directaddress.net