



Pinnacle Gastroenterology  
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 Little Rock, AR 72205  
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 Email-referrals@pinnacleAR.com

### PROVIDER REFERRAL FORM

|                  |  |                |  |
|------------------|--|----------------|--|
| Provider Name:   |  | Patient Name:  |  |
| Clinic/Practice: |  | Date of Birth: |  |
| Address:         |  | Gender:        |  |
| City/State/ZIP:  |  | Address:       |  |
| Phone:           |  | Phone:         |  |
| Fax/Email:       |  | Insurance:     |  |

#### Reason for Referral (check all that apply)

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Colonoscopy Screening   | <input type="checkbox"/> Upper Endoscopy (EGD)      | <input type="checkbox"/> Hepatology Evaluation |
| <input type="checkbox"/> GERD/Reflux/Barrett's   | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> GI Bleeding/Anemia    |
| <input type="checkbox"/> Abdominal Pain/Bloating | <input type="checkbox"/> Diarrhea/Constipation      | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Pancreatic Disease      | <input type="checkbox"/> Cancer Screening/Follow-up | <input type="checkbox"/> Other: _____          |

#### Clinical Information

History/Diagnosis: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Med/Surg History: \_\_\_\_\_ Family History: \_\_\_\_\_

Medications/Allergies: \_\_\_\_\_ Previous GI Procedures: \_\_\_\_\_

Labs/Imaging Attached:  Yes  No

#### Appointment Preference & Authorization

First Available  Urgent (1-2 weeks)  Routine  Specific Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

|  |
|--|
| FOR OFFICE USE ONLY: Date Received: _____ Appointment: _____ Provider: _____ Notes: _____<br>Please fax completed form to (501) 246-4636 or email referrals@pinnacleAR.com<br>This form contains confidential patient information intended solely for medical purposes at Pinnacle Gastroenterology.<br>Unauthorized use, disclosure, or distribution is prohibited under HIPAA regulations. |
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