206 N. Dean Rd. Suite 110
Orlando, FL 32825
Phone: (407)900-7184 Fax: 407-420-0103

GI URGENT CARE OF FLORIDA

Referral Form

Date: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Patient Name: _____ DOB: _____

Reason for Referral:

- ☐ Abdominal Pain/Discomfort
- ☐ Anal/Rectal Pain or Itchining
- ☐ Black Stool
- ☐ Bloating/Belching/Gas
- ☐ Change of Bowel Habits
- ☐ Constipation
- ☐ Diarrhea/Loose Stool
- ☐ Difficulty Swallowing
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Mucus in Stool
- ☐ Nausea/Vomiting
- ☐ Pain w/ Bowel Movements
- ☐ Rectal Bleeding

Other:_____

Diagnosis: _____ If Yes: Date of Imaging_____

Has Patient had Imaging Completed: Yes or No (circle one)

Where was Imaging completed? _____

Past Medical History:

_____
_____
_____
_____

Allergies:

_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____

_____ _____

Requesting Physician's Signature Date

The completed form needs to be faxed to 407-420-0103 **Please ensure to attach patient demographics, insurance information, last office visit note, any pertinent labs, radiology and clearances.**