Gastroenterology of the Rockies

P. 303.604.5000
F. 720.890.0364
www.gastrorockies.com

REFERRAL REQUEST

Today's Date: _____

*Referring Provider: _____
*Office # _____ Fax # _____
Referring Physician Address: _____
_____

*Patient Name: _____
*DOB: _____ Patient Phone # _____
Patient Mailing Address: _____
_____

Patient Insurance: _____
Subscriber Name: _____ DOB: _____
Group # _____ ID # _____

*Diagnosis: _____
ICD-9 Code(s): _____

*Request:
□ Diagnostic Colonoscopy □ Screening Colonoscopy
□ Office Visit to evaluate/treat □ EGD

Please send all lab(s), dictation(s), procedure note(s) & imaging related to the patient's GI problems to us via our **medical fax line** **720.890.0364**