1014 Forsyth Street● Macon, Georgia 31201 ●
Office: (478) 633-4373● Fax: (478) 633-4374
Email HBTCofGA@mccg.org

Referral Dept
Attn: Roy Roberts RN/Christy Lewis CGRN
Fax: 478-633-4374
Phone: 478-633-4373

Please fill out this form to its entirety. One of the referral coordinators will contact your patient with an appointment and notify you of date and time. Please only use this referral for patients that maybe considering linx or surgical intervention for reflux.

Referring MD Name: ______________________________ **NPI #:**____________________

MD Address: ____

MD Phone #: ( )____________________________ **MD Fax #: ( )**________________________

Person Requesting Referral:___________________________ **Extension:**______________________

Nature of Problem/Reason for Referral:

____

____

Patient Name: ____

DOB:______________________**SS#:**________________________________ **Sex:**______________

Home Address; ____

Home Phone#: ( ) _________________________ **Cell Phone#: ( )** ______________________

Insurance Carrier: ________________ **Group#**______________ **Policy#**____________________

Guarantor:__________________________ **DOB:**__________ **Relation to pt:**________________

***Has Patient been seen by another GI?** ______ **Who?** ____________________ **When?** __________

***Has Patient recently had any gastroenterology procedures?**

If so, What?___________________________________**When?**______________________________

Appointment is With________________________________ **Date & Time**________________________

*****Please send a copy of patient demographic information, front and back of insurance card, office notes, medication list, and pertinent results. THANK YOU!!**

We appreciate your referral and look forward to caring for your patient.