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Office 214-617-2000 Fax 214-617-2222

Note: you may have to dial "1" before fax number

REFERRAL DATE: _____

REFERRING PHYSICIAN NAME/GROUP: _____

Office # _____ Fax # _____

REFERRED PATIENT'S NAME _____ **Date of Birth** _____

Home # _____ Work # _____ Cell # _____

Stat Request: YES or NO

☐ Office Consult

☐ Screening Colonoscopy (patient has no gastrointestinal signs/symptoms/conditions)

Diagnosis: _____

**** Please fax pertinent notes, labs and imaging to 214-617-2222 ****

Office Use Only

Your patient is scheduled on: _____

☐ Patient declined to schedule appointment / procedure.

☐ Patient cancelled appointment / procedure.

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