

Specialty Service Referral Gastroenterology

SBL Gastroenterology
1000 Health Center Dr., Suite 204 • Mattoon, IL 61938
217-258-4155 • Fax 217-258-4138



REFERRING PROVIDER

Name _____ Phone _____ Fax _____
Reason for Referral _____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____
Address _____ City _____ State/Zip _____
Phone _____ County _____
Insurance Carrier Primary _____ Secondary _____
If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____
Work Related Yes No If yes, Employer _____ Contact _____
Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- Provider Notes
- Procedure Reports
- Appropriate Laboratory Reports
- Appropriate Imaging Reports
- Medication and Allergy Lists

Procedure Requested

- Office visit
- Colonoscopy
- Endoscopy
- Hemorrhoid banding
- Other _____

REFERRING RESPONSE

- Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

- Patient NOT Scheduled

Additional Information Required _____

Other Reason _____