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Madison, MS 39110
601/355-1234

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Vicksburg, MS 39180
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Referral

Referred to: Lowry ANY GI ASSOCIATES PHYSICIAN – NOT URGENT NEXT AVAILABLE APPOINTMENT – URGENT

Preferred Location: Flowood Madison Vicksburg

Referring Physician First & Last Name: _____ Phone: _____ Date ____/____/____

FOR OFFICE VISIT / CONSULTATION Reason for appointment: _____

If you prefer to call for a referral to GI Associates, please contact one of the physician assistants listed below:

• Assistant to Dr. Lowry: 601-355-1234 ext. 395

Diagnosis

- | | | |
|--|---|---|
| <input type="checkbox"/> Iron deficiency anemia (D50.9) | <input type="checkbox"/> Melena / Blood in stool (K92.1) | <input type="checkbox"/> Nausea / Vomiting (R11.2) |
| <input type="checkbox"/> Abnormal colon or x-ray studies (R93.3) | <input type="checkbox"/> Unexplained diarrhea (R19.7) | <input type="checkbox"/> Abdominal pain, unspecified site (R10.9) |
| <input type="checkbox"/> Hematemesis / coffee grounds emesis (K92.0) | <input type="checkbox"/> Functional diarrhea (K59.1) | <input type="checkbox"/> Dysphagia / Odynophagia (R13.10) |
| <input type="checkbox"/> R/O Hirschsprung's | <input type="checkbox"/> Unspecified obstruction of GI tract (K56.60) | <input type="checkbox"/> Reflux (K21.9) |
| <input type="checkbox"/> Elevated liver enzymes (R74.8) | <input type="checkbox"/> Constipation (K59.00) | <input type="checkbox"/> Weight loss (R63.4) |
| <input type="checkbox"/> Hyperbilirubinemia(E80.6) | <input type="checkbox"/> Change in bowel habits (R19.4) | <input type="checkbox"/> Epigastric pain (R10.13) |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Failure to thrive (R62.51) | <input type="checkbox"/> Other _____ |

Patient Demographic

First Name _____ MI _____ Last Name _____
 Date of Birth ____ / ____ / ____ SSN _____ E-Mail _____
 Address _____
 City _____ State _____ Zip _____ Gender M / F
 Home Phone _____ Work Phone _____ Cell Phone _____
 Name of Legal Guardian _____ Contact Number _____

Insurance Information [Please fill out or include a copy of patient insurance card (front and back)]

Insurance Carrier _____ Policy # _____ Group # _____
 Insured Name _____ Insured SSN _____ Insured Date of Birth ____ / ____ / ____
 Insured Employer _____
 Patient's Relationship to Insured _____ Is Insured the same as Guarantor? Y / N
 Guarantor First Name _____ Guarantor Last Name _____
 Guarantor SSN _____ Guarantor DOB ____ / ____ / ____ Guarantor Phone _____

Please Fax to 601-326-3565