CARLISLE DIGESTIVE DISEASE ASSOCIATES,

CARLISLE ENDOSCOPY CENTER, LTD.

Board Certified Gastroenterologists
Robert Levy, D.O.
Jonathan Verrecchio, D.O.
Patrick McDevitt, D.O.
Tareq Yasin, M.D.
Atul Bhardwaj, M.D.
Michelle DeLeon, C.R.N.P
Jade Means, PA-C
Kristine Kuhn, PA-C

PATIENT REFERRAL FORM

Referring Physician: _____ **Date:** _____

OFFICE REFERRAL **Fax: 245-0806**

Problem/Diagnosis:

_____
_____
_____
_____

OPEN ACCESS ENDOSCOPY REFERRAL **Fax: 245-0720**

Procedure: _____

Indication:

Screening for colorectal cancer: _____
History of polyps: _____
Family hx of colorectal cancer/polyps: _____
Rectal bleed/Heme + stools: _____
GERD: _____

Patient Name: _____ **DOB:** _____ **SS#:** _____

Address: _____

Home Phone: _____ **Alt. Phone:** _____ **May We Leave a Message?** _____

Insurance _____ **ID#**_____ **Group#**_____

Precert _____**Yes** _____**No** **Authorization #**_____

Attachments: Please check all that are sent

Patient's medical history and recent office note (with indications) ☐ **(Required)**

List of patient's current medications and allergies ☐ **(Required)**

Recent labs, EKG ☐

X-rays/CT scans/Ultrasounds ☐

Copy of insurance cards ☐ **(Required)**

Internal Use Only: Appointment Scheduled _____ Provider _____

241 Alexander Spring Road • Carlisle • Pennsylvania • 17015
Phone 717-245-2228 • Fax 717-245-0806 (CDDA) or 717-245-0720 (CEC)