Gastroenterology
& Hepatology
ASSOCIATES OF MID-MICHIGAN, PC

4230 Bay City Rd, Midland, MI 48642
Phone 989-839-0750

REFERRAL FORM

Please circle one

*Dr. Todd Holtz, MD *Dr. Ernest Ofori-Darko, MD *Dr. Christina Murphy, DO *Dr. Karen Huang, DO
**Susan Knoerr, DNP, FNP-C **Leann Schwedler, NP-C

Referring Doctor____

REFERRAL FOR: *OFFICE VISIT *EGD *COLONOSCOPY *FLEX SIGMOIDOSCOPY *ERCP *GIVENS CAPSULE ENDO

DIAGNOSIS:____
(Please fax all testing related to diagnosis and please be specific)

Last Name:________________________ MI______ First Name:________________________

D.O.B: ________________ Soc. Security # _____/____/________ SEX: M/F

ADDRESS:____

CITY:______________________________ STATE:_______ ZIP CODE___________________

PREFERRED PHONE:_________________________ ALTERNATE PHONE:_____________________

PRIMARY INSURANCE:________________________ CONTRACT OR ENROLLEE ID:______________

SECONDARY INSURANCE:______________________ CONTRACT OR ENROLLEE ID:______________

****PLEASE OBTAIN ANY GLOBAL PRIOR AUTHORIZATION NEEDED FOR THIS APPOINTMENT****
PLEASE CIRCLE ANY THAT APPLY

**CARDIAC PROCEDURES WITHIN 1 YEAR **BLOOD THINNERS **ASPIRIN **PLAVIX **COUMADIN

**DIABETES **OXYGEN DEPENDENT **INTERPRETER NEEDED **EMPHYSEMA/SEVERE COPD

**HX OF ADVERSE REACTION TO SEDATION/ANESTHESIA

**PREVIOUS COLONOSCOPY: YEAR______________

FINDINGS__________________________________ (include report and pathology)

PLEASE FAX THIS FORM TO 989-839-9037 **IF NOTES AREN'T ATTACHED REFERRAL WILL BE FAXED BACK AS INCOMPLETE.