

Gastroenterology Consultation Request

Date: [Insert Date]

Referring Physician: [Insert Referring Physician's Name]

Contact Information: [Insert Phone Number and Email]

Patient Information:

Name: [Insert Patient Name]

Birth Date: [Insert Patient Birth Date]

Gender: [Insert Patient Gender]

Insurance Information: [Insert Insurance Details]

Reason for Consultation:

[Insert detailed reason for the consultation]

Medical History:

[Insert relevant medical history of the patient]

Current Medications:

[List current medications]

Relevant Tests/Records:

[List any previous tests or documents attached]

Preferred Appointment Date/Time:

[Insert preferred date/time if applicable]

Thank you for your attention to this matter.

Sincerely,

[Referring Physician's Name]

[Referring Physician's Signature]

[Referring Physician's Contact Information]