

**Office Locations:**

- 7710 Mercy Road, Suite 2000, Omaha, NE. 68124
- 6901 N 72nd St., Suite 3300, Omaha, NE. 68122
- 16901 Lakeside Hills Ct., Omaha, NE. 68130

**Please fax this completed form to Scheduling:  
(402) 717-6068**

**Referral Form**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_

**Appointment Type Requested:**

- ☐ Office Visit/Consult   ☐ Upper Endoscopy   ☐ Colonoscopy   ☐ Panendoscopy  
☐ Other: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

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**For Urgent Requests:** Fax the form to (402) 717-6068, and call (402) 717-9800 immediately.

**For All Other Requests:** Fax the completed form to (402) 717-6068, attention Gastroenterology Scheduling.

**Required Attachments:** Please include copies of the patient's most recent office visit notes, lab results, imaging reports, and any prior procedure documentation (if applicable).

**Internal Use Only**☐ **Patient Scheduled**

Date: \_\_\_\_\_

Location: \_\_\_\_\_

Provider: \_\_\_\_\_

☐ **Patient Not Scheduled**

☐ Patient Refused: \_\_\_\_\_

☐ Unavailable to Contact

☐ 1st Attempt: \_\_\_\_\_

☐ 2nd Attempt: \_\_\_\_\_

☐ 3rd Attempt

☐ Letter sent \_\_\_\_\_