Digestive Specialists, Inc.
Digestive Endoscopy Center, LLC
Redefining Your GI Experience

1-Step GI Referral

Fax **937-293-8772**

DigestiveSpecialists.com
GI Hotline: **937-534-7330**

PATIENT DEMOGRAPHICS

Date _____ **Patient Name**_____ **DOB** _____ **Male/Female/Other**

Cell Phone _____ **Home Phone** _____ **E-mail** _____

Patient Address _____

Referring Doctor _____ **Phone** _____ **Fax** _____

Person Completing Form _____

Providing the home address and/or e-mail will help us reach your patient if he/she is unavailable by phone.

PHYSICIAN & LOCATION PREFERENCE

Preferred Physician (select from right)

☐ **Urgent**

1st Available (choose below)

☐ Any
☐ 1st Available Male
☐ 1st Available Female

☐ David M. **Novick**, M.D.
☐ Marios **Pouagare**, M.D., Ph.D.
☐ Teressa **Patrick**, M.D.
☐ Narayan **Peddanna**, M.D.
☐ Rajkamal **Jit**, M.D.
☐ Bikram **Verma**, M.D.
☐ Malay K. **Dey**, M.D., Ph.D.
☐ Christopher **Barde**, M.D.
☐ Jigna **Thakore**, M.D.
☐ Salma **Akram**, M.D.
☐ Nagaraja **Oruganti**, M.D.
☐ Urmee **Siraj**, M.D.
☐ Kanan **Sharma**, M.D.
☐ Tristan **Handler**, M.D.
☐ Mustafa **Musleh**, M.D.
☐ Jonathan **Kushner**, M.D.

Preferred Location ☐ Dayton (North) ☐ Huber Heights ☐ Springboro ☐ Sugarcreek Township (Dayton)

APPOINTMENT TYPE

☐ **Screening Colonoscopy**
Routine, without GI Symptoms

☐ **Colonoscopy** — with GI symptoms

Reason: _____

_____

☐ **EGD** — ☐ with consult ☐ without consult

Reason: _____

_____

Consultation for Evaluation/Treatment

☐ Reason: _____

_____

_____

☐ EUS — ☐ with consult ☐ without consult
☐ Esophageal Motility — ☐ with consult ☐ without consult
☐ Anorectal Motility — ☐ with consult ☐ without consult
☐ Hemorrhoid Banding
☐ FibroScan — ☐ with consult ☐ without consult

*PLEASE FAX LAST OFFICE VISIT, LABS, RADIOLOGY & OTHER TESTS TO 937-297-2203

FAXED ☐ **YES** ☐ **NO** ☐ **N/A** *If records are not sent at the time of referral, scheduling may be delayed

Digestive Specialists staff will complete the section below:

Scheduled with _____ Appointment Location _____

Appointment Date _____ Appointment Time _____

Date faxed to referring Dr. _____ Labs Received ☐ Yes ☐ No

Patient # _____ Scheduler _____