Wiregrass
SURGICAL

Flowers Hospital Doctor's Center
4300 West Main St., Ste. 24, Dothan, AL 36305
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www.wiregrasssurgical.com

WIREGRASS SURGICAL REFERRAL FORM

Date: _____ Referring Physician: _____

Referring Physician Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____

Telephone Numbers - Home: _____ Work/Cell/Alt: _____

SSN: _____ Insurance Carrier (Send Copy of Card): _____
(We must have a copy of the patient's insurance card, front & back.)

Contract/Policy No: _____ Group Number: _____

REFERRAL INFORMATION

The patient is being referred for:

_____ General Consultation	_____ EGD	_____ Vascular Consultation
_____ Robotic Consultation	_____ Colonoscopy	_____ Vascular US (Carotid, Aorta, Lower Extremities)
_____ Breast Consultation	_____ H. Pylori Consultation	_____ Genetic Testing Consultation

Indication: (Please mark all that apply)

□ Screening/Colonoscopy	□ Gastritis	□ Breast Care	□ Vascular Disease Screening
□ Blood in Stool	□ Dyspepsia	□ Hernia Repair	□ Varicose Veins
□ Family Hx of Colon Cancer	□ Esophagitis	□ Gallbladder Disease	□ AAA □ Carotid US
□ Abdominal Pain	□ Dysphagia	□ Breast Abnormality	□ Weight Loss
□ Hemorrhage of GI Tract	□ Reflux	□ Skin Cancer	□ Other _____

PHYSICIAN PREFERENCE
(First available or circle one)

Steven M. Fendley, M.D., FACS Scott B. Robbins, M.D. R. Burton Pfeiffer III, M.D., FACS (Vascular Surgeon)

Bradley T. Marker, M.D. Emily E. Cannon, M.D.

PLEASE FAX THIS FORM TO US AT 334-793-6840 WITH RECORDS, TESTS, LABS, FRONT & BACK OF THE PATIENTS INSURANCE CARD. WE WILL CALL THE PATIENT AND SET UP THE REQUESTED APPOINTMENT.

*OFFICE USE ONLY— DO NOT WRITE BELOW THIS AREA.

Appt. Date: _____Appt. Time: _____AM/PM *with* Dr. _____

WS EMPLOYEE WITNESS _____