Wiregrass
SURGICAL

4300 West Main St., Ste. 24, Dothan, AL 36305

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www.wiregrasssurgical.com

WIREGRASS SURGICAL REFERRAL FORM – *GENERAL SURGERY*

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
_____ Robotic Consultation
_____ Breast Consultation
_____ EGD
_____ Colonoscopy
_____ H. Pylori Consultation
_____ Genetic Testing Consultation

Indication: (Please mark all that apply)

☐ Screening/Colonoscopy
☐ Blood in Stool
☐ Family Hx of Colon Cancer
☐ Abdominal Pain
☐ Hemorrhage of GI Tract
☐ Gastritis
☐ Dyspepsia
☐ Esophagitis
☐ Dysphagia
☐ Reflux
☐ Breast Care
☐ Hernia Repair
☐ Gallbladder Disease
☐ Breast Abnormality
☐ Skin Cancer
☐ Hemorrhoid
☐ Diverticulitis
☐ Thyroid/Parathyroid Disease
☐ Weight Loss
☐ Other _____

PHYSICIAN PREFERENCE

(First available or circle one)

◯ Steven M. Fendley, M.D., FACS ◯ Bradley T. Marker, M.D., FACS ◯ Emily E. Cannon, M.D., FACS

◯ Kyle M. Bess, M.D. ◯ J. David Roy, 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 _____