



Request for Referral to Gastroenterology

Referral Status (circle one): **STAT** **Urgent** **Routine**

Date: ____/____/____

Referring Provider: _____

Practice Name: _____

Practice phone: _____

Practice fax: _____

Patient First Name: _____

Patient Last Name: _____

Date of Birth: ____/____/____

Copy of insurance card attached (required)

Best contact phone: _____

Medical Insurance ID #: _____

Patient Address: _____

Reason for referral: office consult screening colonoscopy (without office consult)

Direct scheduling: Please specify procedure requested (referring MD states no office consult needed before procedure):

Procedure requested: _____

Specific question to be addressed in procedure: _____

Diagnosis code (symptoms): _____

Specific Question to be addressed in office consult: _____

Please fax recent/last note, medication list, pertinent labs, copy on insurance card, any GI procedure notes

Refer to: **Next Available** provider or **specific provider** (circle one provider below):

3024 New Bern Ave, Raleigh or 10010 Falls of Neuse Rd, Raleigh

110 Kildaire Park Drive, Cary

Ph: 919-350-5318 Fax: 919-350-7093

Ph: 919-235-6440 Fax: 919-235-1389

Dr Riaz Chowdhury

Dr Dina Ahmad

Dr Adeyemi Lawal

Dr Mohammad Esmadi

Dr Juan Herrera

Dr Paul Oh

Dr Shannon Scholl

Dr Sara Ali (after 6/2025)

Dr Luis Vazquez-Montesino

Please note this form must be completed in its entirety to be processed by WakeMed Gastroenterology.