



Northside Gastroenterology
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Patient Referral Form

Please fill out all patient information so that we are equipped with all the pertinent information to adequately schedule your patient.

Patients Name: _____ **DOB:** _____

Are you referring the patient for (Please Circle)

Colonoscopy EGD Consultation Other-Please explain

Diagnosis: _____

Referring Physician info.: (Phys. Name) _____

Dr. Fax# _____ **Dr. PH#** _____

Appt. date: _____ **Time:** _____

Location: _____ **Dr.:** _____

Does your patient have any of the following health problems or take any of the following medications?

A Defibrillator?	Y	N
Any kidney or heart failure?	Y	N
Any prescribed blood thinners?	Y	N
Aspirin Daily?	Y	N
Diabetic?	Y	N
Difficulty walking or in a wheelchair?	Y	N
Allergy to Latex?	Y	N

Please Send:

- **Patient demographics** with updated contact phone number
- Copy of insurance cards
- Medication list
- Any labs/x-rays/office notes pertaining to the diagnosis

We will call the patient to set up their appointment as soon as we have received all of the above information.

Please fax referral and patient information to: 317-879-3993