Daviess Community Hospital
Washington Surgical Associates

# Request for Consultation

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**Phone: 812-254-8856 Fax: 812-254-4831**

**Date of Request:** _____ **Referring Provider:** _____

**Referring Provider's Fax:** _____ **Referring Provider's Phone:** _____

**Patient Name:** _____ **DOB:** _____

**Patient Home Phone:** _____ **Cell:** _____

**Patient Address:** _____

**Primary Insurance Company**: _____ **Secondary**: _____

**Reason for Referral:** _____

**For colonoscopy or EGD referral, date and facility of previous scope(s):**

_____

********Please include the following documents: patient demographics, medical history including surgeries, medication list, last endoscopy procedure note(s) with pathology results *if not performed at DCH*, radiology and lab results pertinent to the referral.********

## To expedite the referral process, please call our office to schedule a consultation.