



FAX REFERRAL REQUEST

FAX # (210) 227-6951

Section to be filled out by referring physician's office:

REFERRING PHYSICIAN'S NAME: _____
Physician Requested: <input checked="" type="checkbox"/> Eric Lawitz, M.D.
NAME: _____ DOB: _____ FIRST MI LAST
REASON FOR CONSULT:
DX: _____

Please Fax Patients Demographics, Insurance Card, & Records

Section to be filled out by Digestive Diseases Center:

SCHEDULED APPOINTMENT INFORMATION

APPOINTMENT SCHEDULED AS REQUESTED WITH: _____

FOR THE PATIENT TO BE SEEN ON: _____, **AT:** _____

PATIENT NOTIFIED BY: **MAIL** **PHONE** **BY:** _____ **ON** _____