Rutland Digestive Services

A Department of Rutland Regional Medical Center

Referral Form

Name: _____ DOB: _____ AGE: _____

Address: _____

Preferred Phone: _____

Primary Insurance Name: _____ Policy #_____ Group #_____

Secondary Insurance Name: _____ Policy #_____ Group #_____

PLEASE PROVIDE PERTINENT Office Notes, Labs, X-Ray Reports, Endoscopy Report(s) with **Pathology Report(s)** (*If not done at RRMC*) **and Medication Lists**

DIAGNOSIS/REASON FOR VISIT: _____

Must be included to schedule appointment

Referring MD: _____

Fax#: _____ Phone#: _____

Primary Care Physician: _____

(If different than referring provider listed above)

❑ **First Available**

❑ **Specific Provider:** ❑ J. Williams, MD ❑ M. Gleeson, MD, PhD ❑ Donald Bloodworth, NP

Service Appointment Requested (Choose one): ❑ Urgent ❑ Routine

Special Needs: (Wheelchair, Transfer Assist, etc.) _____

Appointment Preferences: Day of Week_____ ❑ AM ❑ PM

Please complete and fax referral form to 802.786.1405

Patient Label