Physician Referral Form

Please fill out the following form and fax to (706) 613-1629 with all records and demographics

☐ **STAT Request** ☐ **Routine Request**

Preference on Office Location – Please Circle One:

ATHENS COMMERCE GREENSBORO HARTWELL LAVONIA WINDER

Patient Name: _____

DOB: _____

Patient Phone Number:

_____

Insurance Carrier:

_____

Reason for Referral / Diagnosis:

_____

_____

Requesting Physician:

_____

Physician Phone # _____ Fax #

_____

Additional Comments:

_____

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Athens Gastroenterology Association will call the patient to set up an appointment. If you have any questions or concerns please contact our office at (706) 613-1625. Thanks!

JEFFREY WILLIAMS, MD

Jamie Williams, NP-C Kayla Weaver, PA-C Katie Head, PA-C