**** *Consult / Referral Forms are now available on-line at www.cccahealth.com* ****

Collom & Carney Clinic ASSOCIATION

5002 Cowhorn Creek Drive
Texarkana, Tx. 75503
Phone: (903) 614-3007
Fax: (903) 614-3519

GASTROENTEROLOGY

☐ CONSULT (Request for advice / opinion) or ☐ REFERRAL (Request for management of care)
(Please only select one request)

REQUESTING PROVIDER INFORMATION

Requesting Provider Name	Requesting Provider Address (street, city, state, zip)

Requesting Provider Telephone	Requesting Provider Fax Number	NPI #
( ) -	( ) -	

APPOINTMENT REQUEST

☐ **Michael J. Paolucci, MD** ☐ **Ayotokunbo Olosunde, MD**

DIAGNOSIS

PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)	Gender
	☐ Male ☐ Female

Address	City, State, Zip

Date of Birth (mm/dd/yyyy)	Social Security #
/ /	- -

Home Telephone	Mobile Telephone	Work Telephone
( ) -	( ) -	( ) - xtn

Does patient need an interpreter?	If yes, what language?
☐ Y ☐ N	

Does the patient have medical insurance?	Name of Insurance Company and Plan Number and Group Number
☐ Y ☐ N	

DOCUMENTATION

Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3521.
Thank you in advance for the request and your cooperation.

Collom & Carney Clinic OFFICE USE ONLYPlease scan form to Chart Note for Clinic Physician

Patient MR #	Patient ID #