DIGESTIVE CARE

Syed A. Samad, MD, FACP, FACG, FASGE, AGAF
Ioannis Papayannis, MD
Beth Holloway, APRN, FNP-C

"Complete GI Care, All Under One Roof"

Pine Bluff
4800 South Hazel St
Pine Bluff, AR 71603
P: (870) 534-5533
F: (870 534-5535

Little Rock
14918 Cantrell Rd
Little Rock, AR 72223
P: (501) 663-4747
F: (501) 663-4757

Russellville
1600 W C PL
Russellville, AR 72801
P: (501) 663-2727
F: (501) 663-2747

PROVIDER REFERRAL FORM

Provider Name:		Patient Name:	
Clinic/Practice:		Date of Birth:	
Address:		Gender:	
City/State/ZIP:		Address:	
Phone:		Phone:	
Fax/Email:		Insurance:	

Reason for Referral (check all that apply)

☐ Colonoscopy Screening	☐ Upper Endoscopy (EGD)	☐ Hepatology Evaluation
☐ GERD/Reflux/Barrett's	☐ Inflammatory Bowel Disease	☐ GI Bleeding/Anemia
☐ Abdominal Pain/Bloating	☐ Diarrhea/Constipation	☐ Liver Disease
☐ Pancreatic Disease	☐ Cancer Screening/Follow-up	☐ Other: _____

Clinical Information

History/Diagnosis: _____ Symptoms: _____

Med/Surg History: _____ Family History: _____

Medications/Allergies: _____ Previous GI Procedures: _____

Labs/Imaging Attached: ☐ Yes ☐ No

Appointment Preference & Authorization

☐ First Available ☐ Urgent (1–2 weeks) ☐ Routine ☐ Specific Date: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY: Date Received: _____ Appointment: _____ Provider: _____ Notes: _____

Please fax completed form to (870) 534-5535 or email Info@ASEC.comm
This form contains confidential patient information intended solely for medical purposes at Digestive Care.
Unauthorized use, disclosure, or distribution is prohibited under HIPAA regulations.