GASTRO VIRGINIA
571-570-1819 (Office)
571-506-2446 (Fax)
www.gastrocentersva.com

GASTROENTEROLOGY CONSULT REQUEST

PATIENT INFORMATION

Patient Full Name : _____
(PLEASE PRINT NAME)

Date Of Birth : _____ / _____ / _____

Address : _____

Phone Number : _____ **Email** : _____

Insurance Provider : _____

Policy ID Number : _____ **Group ID Number** : _____

**Please ensure that all necessary insurance referrals or authorizations are processed and submitted prior to or along with the consult/referral form. **

REFERRING PHYSICIAN INFORMATION

Referring Physicians Name : _____
(PLEASE PRINT NAME)

NPI Number : _____

Office Name : _____

Address : _____

Phone Number : _____ **Email** : _____

REASON(S) FOR REFERRAL

- ☐ **Colonoscopy**
- ☐ **Consultation and Treatment**
- ☐ **Esophagogastroduodenoscopy (EGD)**
- ☐ **Endoscopic Retrograde Cholangiopancreatography (ERCP)**
- ☐ **H Pylori Breath Testing**
- ☐ **Hydrogen Breath Test**
- ☐ **Integrative Nutrition**
- ☐ **Small Bowel Capsule Endoscopy**
- ☐ **Small Intestinal Bacterial Overgrowth (SIBO) Testing**

Other Reason(s), Signs and Symptoms : _____

_____

_____

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GASTROENTEROLOGY CONSULT REQUEST

REFERRAL / AUTHORIZATION INFORMATION

Date of Referral : _____

Referral is Valid Until : _____

Number of Visits Authorized : _____

Authorization Number : _____ *(IF REQUIRED)*

Signature : _____

Date : _____ / _____ / _____

PREFERRED LOCATION(S)

- ☐ **Any / First Available**
- ☐ **Alexandria**
  4660 Kenmore Ave
  Suite 810
  Alexandria VA 22304
- ☐ **Fairfax**
  12011 Route 50
  Suite 506
  Fairfax VA 22033
- ☐ **Falls Church**
  6565 Arlington Blvd
  Suite 420
  Falls Church VA 22042
  (Coming Winter 2026)

PREFERRED PROVIDER(S)

- ☐ **Kirsti Campbell, MD**

REFERRAL SUBMISSION INSTRUCTIONS

Please fax the completed referral form, along with any relevant medical records or information, and the patient's insurance referral (if required) to **571-506-2446.** Ensure all necessary documents are included to prevent delays in processing. Gastro Virginia (GV) is not responsible for any errors, omissions, or delays caused by incomplete or incorrect submissions.

GASTRO VIRGINIA

GASTRO CENTER OF MARYLAND
410-290-6677 (Office)
410-290-6676 (Fax)
www.gastromaryland.com

GASTROENTEROLOGY CONSULT REQUEST

REFERRAL / AUTHORIZATION INFORMATION

Date of Referral : _____

Referral is Valid Until : _____

Number of Visits Authorized : _____

Authorization Number : _____ *(IF REQUIRED)*

Signature : _____

Date : _____ / _____ / _____

PREFERRED LOCATION(S)

- ☐ **Any / First Available**
- ☐ **Annapolis**
  1419 Forest Dr,
  Suite 105
  Annapolis, MD 21403
- ☐ **Bethesda**
  5622 Shields Dr,
  Bethesda, MD 20817
- ☐ **Columbia**
  7120 Minstrel Way,
  Suite 100 & 211
  Columbia, MD 21045

  7130 Minstrel Way,
  Suite 217
  Columbia, MD 21045
- ☐ **Gaithersburg**
  501 N Frederick Ave,
  Suite 204 Gaithersburg, MD
  20877
- ☐ **Olney**
  3405 Olandwood Ct,
  Suite 102
  Olney, MD 20832
- ☐ **Owings Mills**
  6502 Kenilworth Ave,
  Suite 100
  Riverdale, MD 20737
- ☐ **Riverdale**
  6502 Kenilworth Ave,
  Suite 100
  Riverdale, MD 20737
- ☐ **Rockville**
  6502 Kenilworth Ave,
  Suite 100
  Riverdale, MD 20737
- ☐ **Silver Spring**
  10301 Georgia Ave,
  Suite 208
  Silver Spring MD 20901
- ☐ **Timonium**
  1212 York Rd,
  Suite B201
  Lutherville, MD 21093
- ☐ **White Marsh**
  4940 Campbell Blvd,
  Suite 140
  White Marsh, MD 21236

PREFERRED PROVIDER(S)

- ☐ **Rudy Rai, MD**
- ☐ **Pia Prakash, MD**
- ☐ **Josh Rosenbloom, DO**
- ☐ **Eduardo Castillo, MD**
- ☐ **Farzin Rashti, MD**
- ☐ **Dabo Xu, MD**
- ☐ **Dhruv Lowe, MD**
- ☐ **Alexander Mamunes,MD**
- ☐ **Thi Khuc, MD**
- ☐ **Urooj Ahmed, MD**
- ☐ **Monica Passi, MD**
- ☐ **Ryan Byrne, MD**
- ☐ **Rushi Talati, MD**
- ☐ **Jennie Zhang, MD**
- ☐ **Hannah Clevenger, CRNP**
- ☐ **Melissa Nickols, PA-C**
- ☐ **Shaffer Mok, MD** *(Joining May 2026)*
- ☐ **Raymond Richhart, MD** *(Joining Sept. 2026)*
- ☐ **Neha Rajpal, MD** *(Joining Sept. 2026)*
- ☐ **Monica Patel, MD** *(Joining Sept. 2026)*
- ☐ **Any / First Available**

REFERRAL SUBMISSION INSTRUCTIONS

Please fax the completed referral form, along with any relevant medical records or information, and the patient's insurance referral (if required) to **410-290-6676.** Ensure all necessary documents are included to prevent delays in processing. Gastro Center of Maryland (GCM) is not responsible for any errors, omissions, or delays caused by incomplete or incorrect submissions.

GASTRO
CENTER OF MARYLAND