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)**
- ☐ **Endoscopic Ultrasound (EUS)**
- ☐ **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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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

PREFERRED PROVIDER(S)

- ☐ **Rushi Talati, MD**
- ☐ **Ryan Byrne, MD**
- ☐ **Kristi Campbell, 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 **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.