medical associates

David S. Shields, M.D.
Gastroenterology and Hepatology

Physician Referral Request

Date_____

Patient Name_____

Telephone Number _____

Date of Birth_____

Referring Physician_____

Clinical Information_____

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☐ **EGD**

☐ **Colonoscopy**

☐ **Flexible Sigmoidoscopy**

☐ **Consult (evaluate and treat)**

☐ **ERCP**

☐ **ph Monitoring (Bravo)**

☐ **Capsule Endoscopy**

☐ **Breath Test (Lactose)**

Routine ☐ **Urgent** ☐

Please fax copy to Dr. Shields (650) 322-0639 and give original to patient.

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