

GASTRO CENTERS OF PENNSYLVANIA

☎ 484-339-6869 (Office)

☎ 484-214-9609 (Fax)

🌐 www.gastrocenterspa.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 | ☐ H Pylori Breath Testing | ☐ Small Bowel Capsule Endoscopy |
| ☐ Consultation and Treatment | ☐ Hydrogen Breath Test | ☐ Small Intestinal Bacterial Overgrowth (SIBO) Testing |
| ☐ Esophagogastroduodenoscopy (EGD) | ☐ Integrative Nutrition | |
| ☐ Endoscopic Retrograde Cholangiopancreatography (ERCP) | | |

Other Reason(s), : _____
Signs and Symptoms



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REFERRAL / AUTHORIZATION INFORMATION

Date of Referral : _____ Referral is Valid : _____

Until

Number of Visits : _____ Authorization : _____
Authorized Number (IF REQUIRED)

Signature : _____

Date : ____ / ____ / ____

PREFERRED LOCATION(S)

☐ **Malvern**
325 Central Ave
Suite 100
Malvern PA 19355

☐ **King of Prussia**
216 Mall Blvd
Suite 120
King of Prussia PA 19406

PREFERRED PROVIDER(S)

☐ Any / First Available

☐ Johann Hasbun, MD

☐ Alice Pang, MD
(Joining November 2026)

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 **484-214-9609**. Ensure all necessary documents are included to prevent delays in processing. Gastro Centers of Pennsylvania (GCP) is not responsible for any errors, omissions, or delays caused by incomplete or incorrect submissions.

