

Thank you for referring your patient to The GW Medical Faculty Associates. Please indicate the specialty to which you are referring your patient:

- Audiology
- Bariatric Surgery
- Breast Imaging & Intervention
- Breast Surgery
- Cancer & Blood Disorders
- Cardiac Surgery
- Cardiology
- Colon & Rectal Surgery
- Dermatology
- Endocrinology
- Gastroenterology & Liver Diseases
- General Surgery
- Geriatrics & Palliative Medicine
- Gynecologic Oncology
- Hematology
- Infectious Diseases
- Internal Medicine
- Interventional Pain Medicine
- Kidney Disease & Hypertension
- Lifestyle Medicine
- Maternal Fetal Medicine
- Medical Oncology
- Midwifery Services
- Nephrology
- Neurology & Rehabilitation Medicine
- Neurosurgery
- Obstetrics & Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Physical Medicine & Rehabilitation
- Plastic Surgery
- Podiatry
- Primary Care
- Psychiatry
- Pulmonology
- Radiation Oncology
- Radiology
- Rheumatology
- Sleep Disorders
- Thoracic Surgery
- Urogynecology
- Urology
- Vascular Surgery
- Other _____
- Specific Physician _____

Please provide the following so we can schedule an appointment:

<input type="checkbox"/> PERTINENT MEDICAL RECORDS <input type="checkbox"/> PATIENT DEMOGRAPHICS <input type="checkbox"/> INSURANCE INFORMATION AND AUTHORIZATION (IF REQUIRED)	
Referring provider information	
Name:	Practice:
City:	State:
Phone:	Fax:
Office contact:	
Patient information	
Patient name:	<input type="checkbox"/> M <input type="checkbox"/> F
Street address:	
City, State:	Date of birth:
Parent/Guardian:	
Please check preferred contact phone number:	
<input type="checkbox"/> Home:	<input type="checkbox"/> Cell: <input type="checkbox"/> Work:
Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Language:	
Primary Care Provider (IF DIFFERENT FROM REFERRING):	
I am requesting: <input type="checkbox"/> CONSULT ONLY <input type="checkbox"/> ONGOING CARE <input type="checkbox"/> REFERRAL REQUESTED BY PATIENT	
Patient's medical issue	
ICD-10 code:	
Please tell us what specific medical issue to address at this visit:	
Please attach relevant medical records where applicable. This may include progress notes, previous workup for the symptoms the patient is experiencing, labs, pathology, imaging, medication lists, and allergies.	
FAX THIS FORM AND PERTINENT MEDICAL RECORDS TO (202) 677-6120.	