



# VANGUARD SURGICAL IIc

## NEW REFERRAL PROCESS

Referring Provider
Name _____
Phone (____) _____
Fax (____) _____
Optional
Mobile (____) _____
<i>For Dr. Hughes and Taylor Rich APRN use only</i>

Patient
Name _____
DOB _____
Address _____
_____
Phone _____
Email _____

Diagnosis
_____ Gastroparesis
_____ GERD
_____ Other: _____

Insurance Information
Carrier _____
ID # _____
Group # _____

Please fax the following to  
**\*\*\* NEW FAX (844) 812-0089 \*\*\***

Demographics  
Most recent office note  
Most recent upper endoscopy (EGD)  
All gastric emptying studies (GES)

May submit referral digitally



*Improving lives one patient at a time*