

# MEDICAL REFERRAL FORM

**DATE OF REFERRAL**

11/23/2025

**REFERENCE NUMBER**

REF-122757

**PATIENT NAME**

David Martinez

**AGE**

55

**SEX**

Male

**DATE OF BIRTH**

09/25/1970

**INSURANCE PLAN**

Cigna Select

**NETWORK STATUS**

OUT-OF-NETWORK

**ESTIMATED COPAY**

100% Patient Responsibility

**REFERRING TO SPECIALIST**

Dr. Christopher Lee

**SPECIALTY**

Gastroenterology

**NPI NUMBER**

1802470135

**CLINIC/PRACTICE**

Golden Gate Digestive Health

**MAJOR COMPLAINT / PRESENTING SYMPTOMS**

pain, lesion, fatigue

**CLINICAL CONTEXT / HISTORY**

I've been having this chronic abdominal pain that won't go away