Project Access
"Our community cares"
New Haven

Office Use Only
Date Received:_____
Reviewed by:_____
Accepted_____Denied_____
Specialist Name:_____
Appt. Date: _____/____/_____

Referral Form to Specialists

Referring Provider Information	Today's Date: 06 /09 /2022
Provider Name: Dr Tripty Gandhi	☑ Fair Haven CHC ☐ CS-Hill Health ☐ Yale-PCC ☐ Yale-ED ☐ Yale Women Center ☐ HSR-PCC ☐ HSR-ED ☐ Haven Free Clinic ☐ Other
Provider Contact Info: **In order to better serve your patient, it is vital that Project Access be able to reach you** (Cell phone preferred) Cell: 572-982-1462 Other:_____	

Patient Information (Patient Sticker also Acceptable)	
Patient Name: Gerardo48 Caraballo427	Date of Birth: 09 /18 /1969
Street Address: 267 Jenkins Track Suite 94	Patients Preferred Telephone Number
Town (circle one): Branford - East Haven – Guilford – Hamden – New Haven – North Branford – North Haven – Northford – Orange – Wallingford – West Haven - Woodbridge	☑ cell ☐ home ☐ work: 981-672-0972
Patient's Preferred Language: English	Interpreter Needed: Y/N

Specialty Referral Information	
Urgency of Referral (circle one): Within 3 days Within 1 week Within 3 weeks *(Non-urgent referrals are not eligible for Project Access)*	
Type of Specialist Requested: Gastroenterology	
Reason for Referral (please specify need for specialty care and rule out diagnoses): Gastro-esophageal reflux disease with esophagitis, without bleeding	
Duration or Approximate Date of Onset:	ED Visits for this Condition: Y/N No. of Visits : YNHH/St. Raphael/Other
Relevant past medical history:	
Relevant imaging or labs (Please attached any relevant documentation. If none, please state):	
Past treatments for this condition (Please attached any relevant documentation. If none, please state):	
Current Medication List (Please attach list of medications if available):	