

GASTROENTEROLOGY NEW PATIENT REFERRAL FORM

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In order to process a referral, please supply all of the following records and fill out the form in its entirety.

- OFFICE CONSULT** **DIRECT ACCESS EGD** **DIRECT ACCESS COLONOSCOPY**
- DEMOGRAPHICS** (include contact information, social security number if available, and any release of information forms.)
- INSURANCE INFORMATION** (Please include copies of insurance cards, front and back)
- RECENT HISTORY AND PHYSICAL**
- LAST TWO OFFICE NOTES FROM REFERRING/PRIMARY PHYSICIAN**
- ANY PAST COLONOSCOPY REPORTS WITH PATHOLOGY**
- ANY PAST EGD REPORTS WITH PATHOLOGY** (Include any dilation reports, BRAVO pH or Impedance testing).
- IMAGING** (In the past year, please include CT scans, X-Rays, MRI, Ultrasounds pertaining to gastroenterology.)
- SURGERY-** Any prior gastrointestinal surgeries (Please include health system/Surgeon)
- TESTING** (ANY gastric emptying studies, anorectal or esophageal manometry, cookie swallows, esophogram, capsule endoscopy and any other testing related to the function of the gastrointestinal system.)
- LABS:** All labs drawn within the past **1year** – GI related (CBC, CMP, PT/INR Liver profile, Hepatitis, Stool, IBD, etc.)
ALSO ANY PROMETHEUS LABS THAT HAVE BEEN DONE FOR IBD PATIENTS
- EMERGENCY ROOM REPORTS** (Within the past 6 months, related to this referral. I.E. abdominal pain, nausea/vomiting, diarrhea, swallowing difficulties, hematochezia, etc.)
- UPDATED MEDICATION LIST** (Including over-the-counter and herbal remedies).

***** Referrals that do not have all of the completed information will be delayed in processing until all records are received. Please fax records to (574) 537-9384.*****

Patient Name: _____ DOB: _____ AGE: _____

Reason for referral (with ICD-10 codes): _____

Allergies: _____ Latex Allergies? YES or NO

Interpreter needed? YES or NO Primary Language: _____ Date of Referral: _____

Referring Provider: _____ Office Number: _____

Office Fax: _____ Form completed by: _____