spokane digestive CENTER

GASTROENTEROLOGY PATIENT REFERRAL REQUEST FORM

REQUESTING PROVIDER:

Date: _____ Phone: _____ Fax: _____

Requesting Provider: _____

Patient Primary Care Physician: _____

PATIENT INFORMATION:

Male ☐ Female ☐

Patient Name: _____ DOB: _____

Address: _____ SSN: _____

_____

Preferred Phone: _____

INSURANCE INFORMATION:

Primary: _____ Subscriber ID: _____

Secondary: _____ Subscriber ID: _____

REQUESTED:

- ☐ **Consult**
- ☐ **Screening Colon**
- ☐ **Colon**
- ☐ **EGD (upper)**

Diagnosis/Reason: _____

_____

_____

(i.e GERD, Barrett's, history of polyps, family history, diarrhea, etc.)

If you believe the patient needs to be seen earlier than three weeks, please call our office and ask to speak with the on-call physician.

Mark all that apply:

- ☐ Weight loss > 6 kg, unintentional
- ☐ GI blood loss (overt ☐ occult ☐)
- ☐ Anemia, new
- ☐ New onset dysphagia
- ☐ Persistent vomiting
- ☐ Abnormal GI imaging
- ☐ Abdominal mass

FAX 509-838-5961

Please include all pertinent records - chart notes, imaging, labs and other tests.