

REFERRAL FOR CONSULT OR PROCEDURE
Digestive Health and Liver Clinic

STANFORD REFERRAL CENTER

Thank you for choosing Stanford Health Care.

PHONE: 877-254-3762

Physician Helpline: 866-742-4811

FAX: 650-320-9443

- Routine
- Urgent within a week
- Expedited (within a month)

DATE: _____

of PAGES: _____

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____ This form completed by: _____

Medical Group: _____ EMAIL: _____

Phone: _____ Fax: _____ PCP: _____

Address: _____ City: _____ ZIP: _____

PATIENT INFORMATION (Please provide a copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____

DOB: __/__/____ Phone: _____ Email: _____ Gender: M F

Patient's Address: _____

City/State/Zip: _____

Needs Interpreter? Yes No Language: _____

REFERRAL INFORMATION: (Please provide as much detail as possible to assist us in scheduling appropriately)

DIAGNOSIS (ICD CODE): _____

REASON FOR REFERRAL: _____

CONSULT REQUESTED

- Consultation only (Referring MD to prescribe therapy)
- Consult, treat and return to requesting MD when medically stable
- Would you like your patient to be seen by other services at SHC? Yes / No
 - Surgery Nutrition Psychology
 - Other service: _____
- Patient previously seen by another gastroenterologist for the same/similar problem: MD name (if known): _____

PROCEDURE REQUESTED

- Screening Colonoscopy
Date of last colonoscopy: _____
- Surveillance Colonoscopy (history of polyps)
Date of last colonoscopy: _____
Histology of last polyp(s): _____
- Colonoscopy after: FIT Test + other: _____
- Upper GI endoscopy Capsule endoscopy
- Endoscopic ultrasound: Upper Lower
- ERCP (requires consult)
- Balloon enteroscopy (requires consult)
- Endoscopic mucosal resection (requires consult)

MOTILITY STUDIES:

- Esophageal manometry
- 24hr esophageal impedance-pH
- Bravo pH Endoflip
- Breath test: Lactulose Other: _____
- Anorectal Manometry
- Wireless capsule motility (SmartPill)

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FOR CONSULTS:

SUBSPECIALTY REQUESTED:

(for a detailed explanation please go to the Digestive Health Center pages on the Stanford Health Care website)

- General Gastroenterology
 - Inflammatory Bowel Disease
 - Liver
 - Esophagus
 - Motility and Functional Bowel Disease
 - Neurogastroenterology
 - Pelvic Health
 - GI/Pain collaboration
 - Celiac Sprue, Intestinal disorders and Allergic disorders
 - Nutrition/Intestinal Failure/Intestinal Transplant
 - Pancreas/Biliary
 - Therapeutic/Advanced Endoscopy
- Consider procedure: _____
- High risk cancer screening/genetics

FOR PROCEDURES:

REQUIRED FOR PROCEDURE REQUESTS:

Does patient have any of the following? (Check if yes)

- LVAD Pacemaker* Defibrillator*
- Taking aspirin/Plavix/warfarin/anticoagulants*:
 - Can stop medication for procedure
 - Cannot stop medication for procedure
 - Defer to cardiology/neurology/hematology

*MD managing pacemaker/defibrillator/meds:

Name: _____

Tel: _____ Fax: _____

SEDATION/PROCEDURAL CONSIDERATIONS:

- Patient had prior problems with sedation or anesthesia.
- Patient is on chronic pain medications
- Patient has a history of alcohol or drug abuse
- Patient has significant cardio-pulmonary disease
- Patient has significant liver or kidney disease
- Patient has insulin-dependent diabetes
- Patient has other significant systemic disease

DOCUMENTATION REQUIRED (Please fax with this form):

- Recent/relevant typed test results, ie: history & physical, previous colonoscopies/MRI/CT/X-Rays, labs
- Last Colonoscopy and pathology report if appropriate if requesting colonoscopy
- Recent/relevant typed clinic notes
- Proof of Insurance
- Authorization information (if required)

Physician Requested (optional): _____

If Requested Physician is not available, is it OK to schedule with another qualified physician? Yes / No