

Gastroenterology Clinic

Fax 504.903.2149

Patient Label/Stamp

Referral from: BMC EKL LJC LAK
LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/___ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email: _____

Please Indicate Reason for Referral (and obtain pre-appointment workup as below):

- 793.4 Abnormal Imaging Studies (Findings : _____)
- 530.85 Barrett's Esophagus
- 787.91 Chronic Diarrhea (Stool for Ova, cysts, parasites, fecal leukocytes and occult blood)
- 153.9 Colon Cancer previously resected: Date of Resection: ___/___/___
Date of last colonoscopy: ___/___/___
- V16 Colorectal Cancer Family History: [1° relative? yes no]
- 211.3 Colon Polyps on Previous Colonoscopy [Date of last colonoscopy: _____]
- 564.00 Constipation—not improved by dietary modification, stool softeners/laxatives
- 555.9 Crohn's Disease (or 556.9) Ulcerative Colitis (Inflammatory Bowel Disease)
- 536.8 Dyspepsia (Heartburn, Indigestion): not improved by Proton Pump Inhibitor Therapy
(Aciphex, Nexium, Prevacid, Prilosec, Protonix)[***Treat for H. pylori if Antigen Positive Stool]
- 787.20 Dysphagia (Difficulty swallowing solids or liquids)
- 530.81 GERD (Gastro-Esophageal Reflux Disease) not improved by Proton Pump Inhibitor Therapy
(Aciphex, Nexium, Prevacid, Prilosec, Protonix)
- 789.00 Lower Abdominal Pain for Evaluation for GI Etiology
- 792.1 Heme Positive Stool (Blood in stool)
- 280.9 Iron Deficiency Anemia: obtain Iron, TIBC, % Saturation, Ferritin, and Reticulocyte count
- 794.8 Persistently Abnormal Liver Function tests, Liver Disease, Hepatitis (CBC, CMP, Hepatitis Panel,
Ultrasound of Liver)
- 45.23 Routine Screening Colonoscopy
- 533.1 Peptic Ulcer disease (or other ulcer disease: Esophageal, Gastric, Duodenal)
- 783.21 Weight Loss: Suspected GI Etiology
- Other ICD: _____ Diagnosis: _____

Clinical History Relevant to this Referral: _____

Indicate co-morbid conditions for this patient:

Cardiac Disease Pulmonary Disease Anticoagulation Therapy Morbid Obesity

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ___/___/___ Time: ___:___ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 02/19/09