Stanford HEALTH CARE

REFERRAL FOR CONSULT OR PROCEDURE

Digestive Health and Liver Clinic

Thank you for choosing Stanford Health Care.

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

STANFORD REFERRAL CENTER
PHONE: 877-254-3762
Physician Helpline: 866-742-4811
FAX: 650-320-9443
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 mediations
- ☐ 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