NORTHSIDE GASTRO

Treating Diseases of the Liver and Gastrointestinal Tract
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Patient Referral Form

Please fill out all patient information so that we are equipped with all pertinent information to adequately schedule your patient.

Patients Name:_____ DOB:_____

Are you referring the patient for:

Colonoscopy **EGD (endoscopy)** **Consultation** **Other – Please Explain**

Diagnosis:_____

Referring Physician Name:_____

Dr. Fax #:_____ Dr. Ph #:_____

Appt. Date:_____ Time:_____

Location:_____ DR/PA:_____

Does your patient have any of the following health problems or take any of the following medications?

A Defibrillator/Pacemaker?	Y	N	Model Name & #:_____ Serial #: _____
Any kidney or heart failure?	Y	N	
Any ***prescribed*** blood thinners?	Y	N	Medication Name:_____
Diabetic?	Y	N	Medication Name:_____
Difficulty walking or in a wheelchair?	Y	N	
Allergy to Latex?	Y	N	
Using home Oxygen or CPAP?	Y	N	
History of Stroke/Heart attack/Seizures in the last 90 days?	Y	N	
Diagnosed with CDiff in the last 30 days?	Y	N	
Currently on dialysis?	Y	N	
Weight loss medication	Y	N	Medication Name: _____
Tested + for covid?	Y	N	Date: _____

Height: _____ Weight: _____ BMI: _____

Please Send:

- **Patient demographics with updated phone numbers**
- ***Copy* of insurance cards**
- **Medication list**
- **Any labs/x-rays/office notes pertaining to the diagnosis**
- **Previous colonoscopy/endoscopy report and path**

Missing records will delay scheduling until they are received.

We will call the patient to set up their appointment as soon as we have received all of the above information. Please fax referral and patient information to: 317.879.3993