# UAB ENDOSCOPY PATIENT REFERRAL FORM

Date Sent: Referral/ Fax ______________________________

Outside Referring Doctor: ______________________________

Contact Person: ____________ Office #: ____________ Fax#: ____________

PCP Doctor: ______________________________

Contact #: ____________ Office #: ____________ Fax#: ____________

Patient: ______________________________

Address: ______________________________

Phone #: ____________ Mobile Phone #: ____________ Email: ____________

**Insurance:**

Primary: ____________ Policy #: ____________ Group #: ____________

Secondary: ____________ Policy #: ____________ Group #: ____________

**Diagnosis/Indication for Procedure: Please check requested procedure(s) below:**

- ☐ Endoscopic Ultrasound
- ☐ Rectal Endoscopic Ultrasound
- ☐ Endoscopic Ultrasound/Pseudo Drainage
- ☐ Endoscopic Ultrasound/Fine Needle Aspiration
- ☐ Endoscopic Ultrasound/Pelvic Abscess Drain
- ☐ Endoscopic Ultrasound/Celiac Block
- ☐ EGD/EMR
- ☐ EGD/ESD
- ☐ Colonoscopy
- ☐ Colonoscopy/EMR
- ☐ Colonoscopy/ESD
- ☐ Antegrade Double Balloon Enteroscopy
- ☐ Flex Sigmoidoscopy
- ☐ Flex Sigmoidoscopy/RFA
- ☐ ERCP
- ☐ ERCP/Lithotripsy
- ☐ ERCP/Spyglass
- ☐ EGD
- ☐ EGD/RFA
- ☐ EGD/PEG
- ☐ EGD/PEGJ
- ☐ Luminal Stenting
- ☐ Retrograde Double Balloon Enteroscopy
- ☐ Double Balloon Enteroscopy with Direct Percutaneous Jejunostomy Placement

*If procedure requested is EUS, EUS/FNA or EUS/Drainage: the actual images must be sent via PACTS or on a CD to UAB GI Lab Attn: Dr. Peter (Division of Gastroenterology and Hepatology, 1720 2nd Ave. South. BDB 380, Birmingham, AL 35294-0012)*

**Notes:** ______________________________

**SCHEDULING OFFICE USE ONLY:** Procedure Code: ____________ Procedure Date: ____________

Patient Type: ☐ Inpatient or ☐ Bedded Outpatient MRN#: ____________

UAB Attending: ☐ K. Kyanam ☐ S. Peter ☐ A. Ahmed ☐ S. Sanchez-Luna ☐ R. Mulki ☐ I. Perry

Other: ______________________________

______________________________

______________________________

Allergies: ______________________________________________

______________________________________________

Prior Endoscopies: ☐ Yes ☐ No If yes, type and date: ______________________

History of gastric bypass, Billroth or Roux-en-Y: ☐ Yes ☐ No

If yes, which procedure?: ______________________________

Diabetic: ☐ Yes ☐ No If yes, list medications: ______________________

______________________________________________

**Please check if patient has the following:**

☐ Asthma ☐ Emphysema ☐ COPD ☐ Home oxygen ☐ Obstructive sleep apnea

**Please check if patient has had the following done:**

☐ ECHO ☐ CAD ☐ CABG ☐ CHF ☐ MI

LVAD Patient: ☐ Yes ☐ No

CPAP Machine: ☐ Yes ☐ No If yes, the CPAP must be brought to the hospital with patient.

Does the patient see a cardiologist?: ☐ Yes ☐ No If yes, please list physician name and office number:

______________________________________________

Hypertension: ☐ Yes ☐ No

Cardiac Stents: ☐ Yes ☐ No If yes, year(s): ______________________

Does patient have pacemaker/defibrillator?: ☐ Yes ☐ No If yes, please list the maker/model below:

______________________________________________

***Please bring pacemaker/defibrillator card, or the MD office can fax the card.**

Recent Hospitalizations: ☐ Yes ☐ No If yes, please list admitted dates and reasons below:

______________________________________________

______________________________________________

Please list all current medication: ______________________________

______________________________________________

List blood thinners currently being taken (i.e. Coumadin, Plavix, aspirin, fish oil): ______________

______________________________________________

**Patient must have current history and physical or the last clinic visit notes.**

**Please fax all records that correspond to the above marked conditions, including:**

☐ Patient Demographics ☐ Pathology Reports ☐ CAT Scan/MRI/MRCP ☐ Current Lab Work

☐ Abdominal Ultrasounds ☐ Endoscopy Reports

## PLEASE FAX BACK TO 205-934-6855

Every attempt will be made to personally contact your patient. If we cannot reach them, then we will mail them a letter. When we schedule your patient, we will fax the appointment date and time to your office.

We thank you for the opportunity to be of service and care for your patient.

**Please feel free to contact our office at 205-934-6895.**