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IOWA DIGESTIVE DISEASE CENTER

GASTROENTEROLOGY, HEPATOLOGY, DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY AND COLORECTAL SURGERY

Clinic Consultation Form

Please forward any pertinent: Labs, Office Notes, Radiology Reports, CT Scans, ultrasound, any EGD or Colonoscopy reports along with Insurance Cards, and Medication List.

In order for us to provide you and your patient timely and efficient service, we ask that you complete this form and fax to our Scheduling Department at **(515)288-8335.**

Which physician or provider in our practice are you requesting services from? (Please circle one below.)

ANY PROVIDER OR SPECIFIC PROVIDER________________

Is this an URGENT Referral? (Does the patient need to be seen within one week?) Circle: Yes / No

Reason for Consultation

Reason for referral? (Please circle all that apply.)

- Anemia - Blood-in-stool - Change in Bowel Habits - Constipation - Diarrhea - GERD

- Dysphagia - Rectal Bleeding - Nausea/Vomiting - Abdominal pain - IBD - IBS

- Liver Disease (Hepatitis B, Hepatitis C, Fatty liver, Other) Other: ____

Has the patient had abnormal abdominal imaging? Circle: Yes / No If yes, please specify: ______________

Has the patient had abnormal liver labs? Circle: Yes / No

Has the patient had abnormal pancreatic enzymes? Circle: Yes / No

Is the patient pregnant? Circle: Yes / No

Patient Information

Referring Provider:____Phone: ________________________

Person Making this Request:______________________________Fax: ___________________________

Has the patient been seen by any GI provider in the office or hospital? Circle: Yes / No

If yes, by whom? ______________________________

Patient Name:____DOB:_________________________Circle: Male Female

Patient's Street Address:_________________________________City:_____________________State:______Zip Code: ______________

Patient's Phone:________________________________Circle: Work / Cell / Other

Patient's Email:____

Does the patient read and understand the English language: Circle: Yes / No

Is a sign language/or language translator needed? Circle: Yes / No

If yes, which language? ________________

Insurance Information (Include a copy of card with referral.)

Primary Insurance:_________________________________Insurance ID#:_________________________Self or Other: _________

Secondary Insurance:_______________________________Insurance ID#:__________________________Self or Other: ________

Insured's Date of Birth:______________________Contact Information for Primary Insurance: __

Updated 02/16/2024