SUNY Downstate Medical Center

University Hospital of Brooklyn
College of Medicine
School of Graduate Studies
College of Nursing
College of Health Related Professions

Department of Medicine
Division of Gastroenterology & Hepatology

GI Consults/Procedures

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Demographic Data:

Patient _____DOB _____Gender _____
Address _____ Phone (H) _____
_____ (W) _____
SS# _____ SUNYHistory # (if applicable) _____
Insurance _____

Clinical Information

Referring Physician:
_____
Name of contact person in Referring Office
_____
Office phone _____ Pager _____
Fax Number _____
Referring Physicians specialty: _____

Type of visit requested:
Urgent _____< 2 weeks (Give reason) Non-Urgent _____> 2-4 weeks

Reason for referral:

_____

_____

Has the patient been evaluated by a gastroenterologist in the past? Y / N (if yes, please enclose records)
If yes, what diagnosis was made? _____

Laboratory Data (if available)
Biopsy results _____
Tumor Markers? _____
CBC _____

Please send copies of other pertinent labs, endoscopy or X-ray data obtained to date.
Thank You for allowing us to participate in the care of your patient.

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