



DIGESTIVE HEALTH PROGRAM RAPID REFERRAL FORM

Fax to: 757-312-6270

Phone: 757-312-3120 Email: digestivehealth@chesapeakeregional.com

Date of referral: _____
 Referring physician: _____ Address: _____
 Referral coordinator: _____ Phone: _____ Fax: _____

PATIENT INFORMATION:

Last name: _____ First name: _____
 Date of birth (MM/DD/YY): _____ Sex: M F
 Address: _____ City: _____ State: _____ ZIP: _____
 First contact phone: _____ Second contact phone: _____ Email: _____

INSURANCE: (Please provide copy of front and back of insurance card)

Insurance plan: _____ Subscriber ID: _____

PLEASE INCLUDE AS MUCH DOCUMENTATION AS POSSIBLE: H&P, LABS, X-RAYS, CURRENT / PAST TREATMENT, ETC.

PRIORITY Emergent (<48 hours) Urgent (<72 hours) Routine

Colorectal Surgery	Gastroenterology		General Surgery
<input type="checkbox"/> Anal Fissure	<input type="checkbox"/> Colonoscopy screening	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hiatal/paraesophageal hernia
<input type="checkbox"/> Anal Fistula / Abscess	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Biliary disease	<input type="checkbox"/> Incisional/Ventral hernia
<input type="checkbox"/> Anal condyloma / Warts	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Inguinal/Femoral hernia
<input type="checkbox"/> Colon/Rectal cancer	<input type="checkbox"/> Melena	<input type="checkbox"/> GERD / Reflux	<input type="checkbox"/> Umbilical hernia
<input type="checkbox"/> Colitis / Crohn's refractory to medical management	<input type="checkbox"/> Heme + stools	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Visible blood in stool	<input type="checkbox"/> Diaphragmatic / Hiatal hernia	
<input type="checkbox"/> Fecal Incontinence	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Inflammatory Bowel Diseases: Crohn's / Ulcerative colitis	
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Abnormal Liver Tests	Other
<input type="checkbox"/> Rectal Prolapse	<input type="checkbox"/> Constipation	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Abnormal x-rays: please send copies of x-rays
<input type="checkbox"/> Pruritus ani	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Hepatitis	
	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Pancreatitis	

Referring Physician Signature	Date	Time

For official use only:

Date received: ___ / ___ / ___ Date faxed back to provider: ___ / ___ / ___ Initials: _____ Time: _____