CHOC Children's Specialists

Division of Gastroenterology Referral Request

Division Phone: 714.509.4099 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Gastroenterology.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance: _____ Parent Cell: _____

1. Is this an **emergent** Gastroenterology referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD /PA /NP with clinical information to 714.509.4099, option 1**

2. Please describe the patient's chief complaint and *include onset and frequency*:

_____

_____

Please select diagnosis:

☐ **Abdominal Pain**	☐ **Jaundice**
☐ **Diarrhea**	☐ **Constipation**
☐ **Weight Loss**	☐ **Growth Failure**
☐ **GI Bleed**	☐ **Vomiting**
☐ **GERD**	☐ **Other: _____**

Pertinent medical history:

Work up done to date:

☐ **UGI**	☐ **Stool O&P**
☐ **UTZ**	☐ **Stool OB**
☐ **U/A**	☐ **CBC**
☐ **CT Scan-Abdominal**	☐ **ESR**
☐ **CT Scan-Head**	☐ **CHEM 18**
☐ **Stool C&S**	☐ **Other**

Treatment to date:

Other providers treating patient and phone #:

To expedite appointment scheduling, please provide the following by FAX 855-246-2329:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Growth Chart or past heights and weights, lab and test reports done less than 1 year**
- ☐ **Patient demographics**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____