IOWA DIGESTIVE DISEASE CENTER
GASTROENTEROLOGY, HEPATOLOGY, DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY AND COLORECTAL SURGERY

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Kristin Everhart, A.R.N.P.
Lori Mathis, D.N.P., A.R.N.P.

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)
- Dr. Leman - Dr. O'Brien - Dr. Vemulapalli - Dr. Verma - Dr. Roberts - Dr. Myneni - Dr. Martin - Dr. Page
- Dr. Lopes - Dr. Iyer - Dr. Newton - Maria Steele, ARNP - Kristin Everhart, ARNP - Lori Mathis, DNP, ARNP
OR ANY PROVIDER

Is this an URGENT referral (needs to be seen within one week)? Circle Yes / No

Reason for Consultation

Reason for referral? (circle **all** that apply)

- Anemia - Blood-in-stool - Change in Bowel Habits - Constipation - Diarrhea - GERD
- Dysphagia - Rectal Bleeding - Nausea/Vomiting - Abdominal pain - Inflammatory Bowel Disease
- 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 home phone: _____ Other phone: _____ work cell other

What time of day is best to call patient? _____

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:_____