Bernard I. Leman, M.D., F.A.C.G.
Michael D. O'Brien, M.D., F.A.C.G.
Ravi Vemulapalli, M.D.
Archana Verma, M.D.
Stacey S. Roberts, M.D.
Nagendra Myneni, M.D.
Thomas L. Martin, D.O.
Tercio L. Lopes, M.D., M.S.P.H.
Raj Iyer, M.D.
Michael J. Page, M.D.
Arjun Sondhi, M.D.
Christopher Mulder, D.O.
Lori Mathis, D.N.P., A.R.N.P.
Karen Luken, A.R.N.P.
Noelle Mundt, M.S.N., A.R.N.P.
Christina Hendricks, A.R.N.P.
Tiffany Beyer, A.R.N.P.
Megan Brodie, A.R.N.P.
Melissa Halverson, D.N.P., A.R.N.P.
Morgan Hemer, A.R.N.P.

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.)

- Dr. Leman - Dr. O'Brien - Dr. Vemulapalli - Dr. Verma - Dr. Roberts - Dr. Myneni - Dr. Martin - Dr. Page - Dr. Sondhi
- Dr. Lopes - Dr. Iyer - Dr. Mulder - Melissa Halverson, ARNP - Lori Mathis, DNP, ARNP - Karen Luken, ARNP
- Noelle Mundt, ARNP

- OR ANY 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

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: _____

1378 NW 124th Street
Clive, Iowa 50325-8151

3625 N Ankeny Boulevard, Suite D
Ankeny, Iowa 50023-4611

Phone: 515-288-6097
Fax: 515-288-8335