Nazih Zuhdi Transplant Institute

Advanced Interventional Endoscopy Referral Form

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Patient Name: ______________________ DOB: ___________ SSN: _______________

Phone: (H) _______________ (W) ___________________ (C) ___________________

Patient Insurance: ____

Procedure Requested & Required Supporting Documentation

☐ EGD/EMR/RFA
- Most recent office note &/or H&P
- EGD & pathology
- Pertinent imaging (images & reports)

☐ EUS
- Most recent office note &/or H&P
- EGD/Colonoscopy & pathology
- Pertinent lab
- CT/MRI (images & reports)

☐ Deep Balloon Enteroscopy (SBE)
- Most recent office note &/or H&P
- COLOR copy & imaging of Video Capsule Endoscopy (VCE)
- EGD/Colonoscopy & pathology
- Pertinent lab

☐ ERCP/Cholangioscopy/Lithotripsy
- Most recent office note &/or H&P
- LFT's
- Cholangiogram
- Pertinent imaging (images & reports)

☐ Colon EMR/ Rectal Ultrasound
- Most recent office note &/or H&P
- Colonoscopy & pathology
- Pertinent imaging (images & reports)

List of images sent: ____________________
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Has the patient had Gastric Bypass Surgery ☐ **Yes** ☐ **NO**

INDICATIONS for procedure?

☐ Occult GI Bleed
☐ Submucosal Lesion of GI Tract
☐ Pancreatic Stricture
☐ Pancreatic Stones
☐ Chronic Pancreatitis
☐ Pancreatic Mass/Cancer
☐ Pancreatic Cyst
☐ Pancreatic Pseudo Cyst
☐ Barrett's Esophagus
☐ Esophageal Mass/Cancer
☐ Rectal Mass/Cancer
☐ Gastric Mass/Cancer
☐ Bile Duct Stricture
☐ Bile Duct Stones
☐ Lung Cancer Staging
☐ Abnormal VCE

PLEASE SEND THE CAPSULE ENDOSCOPY REPORT IN COLOR.

*We **MUST** have the following: referral sheet with DIAGNOSIS, DEMOGRAPHICS, and INSURANCE information.

*We require EVAL & TREAT AUTHORIZATION TO BE OBTAINED BY YOUR OFFICE for Indian Health Services, SoonerCare, VA, Global Health and Tricare Prime insurances BEFORE referral will be processed.

Referring Physician: ______________________ Phone: ______________________

Physician's Contact: ______________________ Fax: ______________________

Back line number & ext (if applicable): ______________________