

**UNC Gastroenterology Specialty Clinics***A Service of UNC Hospitals*

101 Manning Drive, Chapel Hill, NC 27514

Local: (919) 966-2511 Toll Free: (877) 668-0680 Fax (919) 966-3414

NEW PATIENT REFERRAL/CONSULTATION*Please complete entire form and attach copies of prior pertinent clinic notes, endoscopy reports, path reports, labs, imaging results and discharge summaries. We cannot schedule an appointment until this information is received.***PATIENT INFORMATION****UNC MR# (if known):**

| | | | |
|-----------------|------------------------------------------------------------|-------------|--------------|
| LAST NAME: | | FIRST NAME: | MIDDLE NAME: |
| SSN: | SEX: F <input type="checkbox"/> M <input type="checkbox"/> | BIRTH DATE: | RACE: |
| STREET ADDRESS: | | | HOME PHONE#: |
| CITY: | | STATE: | ZIP |

CHECK SYMPTOM(S)/DIAGNOS(ES)

| | | | | |
|---------------------------------------------------|----------------------------------------------|---------------------------------------------------|-------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Acute Pancreatitis | <input type="checkbox"/> Achalasia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Chronic Abdominal Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bile duct stones | <input type="checkbox"/> Atypical Chest Pain | <input type="checkbox"/> IBD | <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chronic Pancreatitis | <input type="checkbox"/> Barrett's | <input type="checkbox"/> Perineal Crohn's Disease | <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> GI Bleed |
| <input type="checkbox"/> Gallstones | <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Pouchitis | <input type="checkbox"/> Fecal Incontinence | <input type="checkbox"/> GI Malignancies |
| <input type="checkbox"/> Pancreatic Cancer | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Functional Disorders | <input type="checkbox"/> Hematemesis |
| <input type="checkbox"/> Pancreatic Disease | <input type="checkbox"/> Esophageal Disease | | <input type="checkbox"/> IBS | <input type="checkbox"/> Motility Problem |
| <input type="checkbox"/> Pancreatic Insufficiency | <input type="checkbox"/> Esophageal Motility | | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pancreatiobiliary | <input type="checkbox"/> H.pylori | | | |
| | <input type="checkbox"/> Reflux | | | |
| | <input type="checkbox"/> Swallowing Disorder | | | |

- All new patients are seen for an initial consultation at the request of referring physicians. UNC GI faculty will determine the need for transfer of care to UNC at the time of the initial consultation.

SPECIFIC QUESTION(S) TO BE ADDRESSED:Spanish Interpreter Needed? Yes No**PRIMARY CARE PHYSICIAN INFORMATION**

| | | | |
|------------------|------|------------------|--|
| PHYSICIANS NAME: | | | |
| PRACTICE NAME: | | | |
| STREET ADDRESS: | | CITY, STATE, ZIP | |
| PHONE: | FAX: | EMAIL ADDRESS: | |

REFERRING PHYSICIAN INFORMATION

| | | | |
|------------------|------|------------------|--|
| PHYSICIANS NAME: | | | |
| PRACTICE NAME: | | | |
| STREET ADDRESS: | | CITY, STATE, ZIP | |
| PHONE: | FAX: | EMAIL ADDRESS: | |

**INSURANCE POLICY HOLDER INFORMATION
(PLEASE ALSO ENCLOSE COPY OF INSURANCE CARD)**

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------|-----------------|
| POLICY HOLDER'S RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER | | LAST NAME: | FIRST NAME: |
| SSN: | SEX: F <input type="checkbox"/> M <input type="checkbox"/> | BIRTH DATE: | PRIMARY PHONE: |
| PRIMARY INSURANCE CARRIER: | POLICY #: | GROUP #: | EFFECTIVE DATE: |
| SECONDARY INSURANCE CARRIER: | POLICY #: | GROUP #: | EFFECTIVE DATE: |