**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: |
| PRIMARY PHONE: | ALTERNATE PHONE: | SEX: F ☐ M ☐ | BIRTH DATE: |
| RACE: | STREET ADDRESS: | | |
| CITY: | STATE: | ZIP: | |

## CHECK SYMPTOM(S)/DIAGNOS(ES)

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

- *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<br>*(PLEASE ALSO ENCLOSE COPY OF INSURANCE CARD)* | | | |
|---|---|---|---|
| POLICY HOLDER'S RELATIONSHIP TO PATIENT:<br>☐SELF ☐PARENT ☐SPOUSE ☐CHILD ☐OTHER | LAST NAME: | | FIRST NAME: |
| SEX: F ☐ M ☐ | BIRTH DATE: | | PRIMARY PHONE: |
| PRIMARY INSURANCE CARRIER: | POLICY #: | GROUP #: | EFFECTIVE DATE: |
| SECONDARY INSURANCE CARRIER: | POLICY #: | GROUP #: | EFFECTIVE DATE: |