

**UNC GASTROENTEROLOGY SPECIALTY CLINICS**

**A SERVICE OF UNC HOSPITAL**

101 Manning Drive, Chapel Hill, NC 27514

Local: 966-0141 Toll Free: (877) 668-0680 FAX: (919) 966-2250

**Facsimile Transmittal**

To: \_\_\_\_\_ From: \_\_\_\_\_  
Fax: \_\_\_\_\_ Pages: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ CC: \_\_\_\_\_

**INSTRUCTIONS NEW PATIENT REFERRALS OR CONSULTATIONS**

Please fill out the forms completely, especially:

- ❖ Name and address of the referring physician
- ❖ Insurance information including the policy and social security numbers.

Complete a separate form for each patient. Thank you for your cooperation.

**APPOINTMENT CONFIRMATION**

Date:	
Patient Name:	
Appointment Date and Time:	
Appointment With:	
Scheduler's Name:	

*The information contained in this facsimile is Privileged and Confidential, intended only for the use of the addressee. You are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this in error, please notify the sender immediately by telephone and return the original message to the sender via US Postal Service.*

**Attention:** \_\_\_\_\_

To learn more about the Functional Bowel/IBS Program visit our website: [www.med.unc.edu/ibs](http://www.med.unc.edu/ibs)

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**FUNCTIONAL /IBS NEW PATIENT REFERRALS**

**Date:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax: #:** \_\_\_\_\_

Dear \_\_\_\_\_,

Thank you for your recent referral to the UNC HOSPITAL GASTROENTEROLOGY SPECIALTY Clinic. We have received only part of the information we need to complete this referral. Please send us the items indicated below to help us process this referral in a timely fashion. **We cannot make an appointment without ALL of this information.** Thank you for the continued support in helping us get your patient an appointment as quickly as possible.

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**MISSING ITEMS:**

\_\_\_\_\_ Patient demographic data form

\_\_\_\_\_ Doctor address and contact information form

\_\_\_\_\_ Patient insurance information form/readable front and back copy of insurance card(s).

\_\_\_\_\_ Pertinent medical records (recent clinic visits, recent labs, and relevant GI procedures)

\_\_\_\_\_ Letter of referral from doctor or a detailed UNC consultation form: this letter/form should summarize the patient's symptom(s) history, treatments and tests that have been done, and the specific questions the referring doctor wishes to be addressed in our clinic. **REFERRALS WITHOUT A LETTER OR THE DETAILED CONSULTATION FORM FROM THE DOCTOR WILL NOT BE PROCESSED.**

THANK YOU!

Linda Miller

Office Assistant for Dr. Douglas Drossman and staff

Phone: 919-966-0141

Fax: 919-966-2250

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**TO:** UNC GI SPECIALTY CLINICS **FROM:** \_\_\_\_\_

**PAGES:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**DATE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ **Re:** \_\_\_\_\_

**After completing both forms, please fax along with the copies of prior pertinent clinic notes, endoscopy reports, path reports, labs, imaging results, and discharge summaries. Upon receipt, of all necessary information an appointment will be scheduled. Thank you for allowing us to participate in your patient's care!**

**CHECK SYMPTOM(S)/DIAGNOSE(S):**

<input type="checkbox"/> Acute Pancreatitis <input type="checkbox"/> Bile duct stones <input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Gallstones <input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> Pancreatic Disease <input type="checkbox"/> Pancreatic Insufficiency <input type="checkbox"/> Pancreatobiliary	<input type="checkbox"/> Achalasia <input type="checkbox"/> Atypical Chest Pain <input type="checkbox"/> Barrett's <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Dysphagia <input type="checkbox"/> Esophageal Disease <input type="checkbox"/> Esophageal Motility <input type="checkbox"/> H.pylori <input type="checkbox"/> Reflux <input type="checkbox"/> Swallowing Disorder	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> IBD <input type="checkbox"/> Perineal Crohn's Disease <input type="checkbox"/> Pouchitis <input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Chronic Abdominal Pain <input type="checkbox"/> Chronic Constipation <input type="checkbox"/> Chronic Diarrhea <input type="checkbox"/> Fecal Incontinence <input type="checkbox"/> Functional Disorders <input type="checkbox"/> IBS	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> GI Bleed <input type="checkbox"/> GI Malignancies <input type="checkbox"/> Hematemesis <input type="checkbox"/> Motility Problem <input type="checkbox"/> Other:
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Spanish Interpreter Needed:  Yes  No

**SPECIFIC QUESTION TO BE ADDRESSED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*\*Note: 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.*

**PHYSICIAN INFORMATION:**

Primary Care Physician's Name: \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_

Gastroenterologist  Primary Care  Surgeon  Other \_\_\_\_\_

Name of Facility \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

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**NEW PATIENT REFERRALS/CONSULTATION**

**Patient Information**

**UNC MR# (if known):**

Last Name		First Name	Middle Name
Soc Sec No	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	Birth Date	Race: U.S. Citizen
Street Address		Home Phone #	
City	State	Zip	

**Responsible Party (the person who pays the patient's portion of the bill) LEAVE BLANK IF SELF\*\*\***

Last Name		First Name, MI	Date of Birth	SEX: F <input type="checkbox"/> M <input type="checkbox"/>
Street Address		Home Phone #		
City	State	Zip		
Employer	Work Phone #	Soc. Sec.#		
Relationship to Patient (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Other				
Emergency Contact		Relationship to Patient	Contact Phone #	

**Email:**

**Primary Insurance Policy Holder Information (Subscriber)**

**COPY OF INSURANCE CARD(S) FRONT AND BACK**

Last Name		First Name MI	Date of Birth	SEX: F <input type="checkbox"/> M <input type="checkbox"/>
Employer Name		Work Phone #	Soc. Sec.#	
Name of Insurance <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> other		Policy #:	Group #:	
Effective Dates of Insurance Coverage	Claims Address (on Insurance Card)			
Patient's Relationship to the Policy Holder- (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
<input type="checkbox"/> Employed FT <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Not Used Unknown <input type="checkbox"/> Employed PT <input type="checkbox"/> Self Employed				

**Secondary Insurance Policy Holder Information**

Last Name		First Name MI	Date of Birth	SEX: F <input type="checkbox"/> M <input type="checkbox"/>
Employer Name		Work Phone #	Soc. Sec.#	
Name of Insurance <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> other		Policy #	Group #	
Effective Dates of Insurance Coverage	Claims Address (on Insurance Card)			
Patient's Relationship to the Policy Holder- (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
<input type="checkbox"/> Employed FT <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired <input type="checkbox"/> Not Used Unknown <input type="checkbox"/> Employed PT <input type="checkbox"/> Self Employed				