



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 <input type="checkbox"/> M <input type="checkbox"/>
RACE:	BIRTH DATE:	
CITY:	STREET ADDRESS:	
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"/> Pancreatobiliary	<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:
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: