

Patient Referral Form

Patient Name _____ circle one: Male Female Non-Binary

Cell Phone _____ Home Phone _____ DOB ____/____/____

Email _____

Referring Provider _____

Phone # _____ Fax # _____

If scheduling a procedure, is the patient taking any of the following **antiplatelet/anticoagulants**? (check the box)

- Plavix (clopidogrel)
- Coumadin (warfarin)
- Aggrenox (ASA/dipyridamole)
- Brilinta (ticagrelor)
- Eliquis (apixaban)
- Pradaxa (dabigatran etexilate)
- Lovenox (enoxaparin)
- Other _____

Appointment: (check the box)

- Consultation
- Colonoscopy
- EGD
- Other _____

Gastroenterology of the Rockies provider: (check the box)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Sim Bedi , DO | <input type="checkbox"/> Raul Cubillas , MD | <input type="checkbox"/> Taimur Khan , MD | <input type="checkbox"/> Ramu Raju , MD |
| <input type="checkbox"/> Joseph Cassara , MD | <input type="checkbox"/> Timothy Dobin , DO | <input type="checkbox"/> Daus Mahnke , MD | <input type="checkbox"/> Matthew Seto , DO |
| <input type="checkbox"/> Rohan Clarke , MD | <input type="checkbox"/> David Gatof , MD | <input type="checkbox"/> Tamas Otrok , MD | <input type="checkbox"/> Joshua Steinberg , MD |
| <input type="checkbox"/> David Cristin , MD | <input type="checkbox"/> Matthew Karowe , MD | <input type="checkbox"/> Wesley Prichard , DO | <input type="checkbox"/> Nathan Susnow , MD |
| <input type="checkbox"/> Victoria Evelyn , PA-C | <input type="checkbox"/> Emily Marshall , PA-C | <input type="checkbox"/> Rachel Povilus , PA-C | <input type="checkbox"/> Kelly Zucker , DO |
| <input type="checkbox"/> Susan Gieske , PA-C | <input type="checkbox"/> Jennifer Meyer , PA-C | <input type="checkbox"/> Brittany Propoggio , PA-C | <input type="checkbox"/> Sarah Schwartz , PA-C |
| <input type="checkbox"/> Gerald Kidd , PA-C | <input type="checkbox"/> Rachel Pierce , PA-C | <input type="checkbox"/> Morgan Reilly , PA-C | <input type="checkbox"/> Katie Vieira , PA-C |
| <input type="checkbox"/> Kevin Lee , PA-C | <input type="checkbox"/> Other _____ | | |

Please indicate the reason for an appointment below: (check the boxes that apply - ICD-10 codes are in bold)

Colonoscopy

- Screening: **Z12.11**
- History of Adenomatous Polyps: **Z86.010**
- Family History: **Z80.0**
- Diarrhea: **R19.7**
- Change in bowel habits: **R19.4**
- Bright red blood per the rectum: **K62.5**
- Hematochezia: **K92.1**
- Anemia: **D64.9**
- Heme positive stools: **R19.5**
- Weight loss: **R63.4**
- Abdominal pain: **R10.84**
- Other _____

EGD

- GERD: **K21.9**
- Chest pain: **R07.9**
- Barrett's Esophagus: **K22.70**
- Dysphagia: **R13.10**
- Melena: **K92.1**
- Abdominal pain: **R10.13**
- Other _____

Other

Consultation: Reason for visit:

Please include pertinent records, labs, imaging, & **attach patient demographics and insurance information.**