

Patient Name: _____

DOB: _____

REFERRAL FOR LOYOLA GASTROENTEROLOGY SERVICES**Please attach the following:**

- Patient contact, ID and/or insurance information; Referring physician fax and contact
- Recent clinic notes from provider including procedure indication/referral request, medical history and medications
- Prior endoscopy report (if available) / any additional relevant labs/scans

FAX COMPLETED REQUEST TO: 708-216-4113**For MD Use Only**Preferred Location: Loyola MacNeal Gottlieb No Preference

Requested service(s):

- Clinic Visit/Consultation Colonoscopy EGD ERCP EUS
- Video Capsule Study Hydrogen Breath Test (SIBO or lactose)
- Esophageal Manometry pH Impedance Anorectal Manometry
- Other (please specify): _____

Diagnosis/ICD10 code(s) _____

- Screening colonoscopy (Z12.11) History of polyps (Z86.010) Diarrhea (R19.7)
- Constipation (K59.01) GERD (K21) Abdominal pain (R10.1)

Sedation: Anesthesia/Propofol Conscious sedation Either/First Available**Special Instructions:** _____**Completed by:** _____ **Date:** _____