CHESAPEAKE REGIONAL HEALTHCARE

DIGESTIVE HEALTH PROGRAM RAPID REFERRAL FORM

Fax to: 757-312-6270

Phone: 757-312-3120 Email: digestivehealth@chesapeakeregional.com

Date of referral: _____

Referring physician: _____ Address: _____

Referral coordinator: _____ Phone: _____ Fax: _____

PATIENT INFORMATION:

Last name: _____ First name: _____

Date of birth (MM/DD/YY): _____ Sex: ☐ **M** ☐ **F**

Address: _____ City: _____ State: _____ ZIP: _____

First contact phone: _____ Second contact phone: _____ Email: _____

INSURANCE: (Please provide copy of front and back of insurance card)

Insurance plan: _____ Subscriber ID: _____

PLEASE INCLUDE AS MUCH DOCUMENTATION AS POSSIBLE: H&P, LABS, X-RAYS, CURRENT / PAST TREATMENT, ETC.

PRIORITY ☐ Emergent (<48 hours) ☐ Urgent (<72 hours) ☐ Routine

Colorectal Surgery	Gastroenterology		General Surgery
☐ **Anal Fissure**	☐ **Colonoscopy screening**	☐ **Anemia**	☐ **Hiatal/paraesophageal hernia**
☐ **Anal Fistula / Abscess**	☐ **Abdominal pain**	☐ **Biliary disease**	☐ **Incisional/Ventral hernia**
☐ **Anal condyloma / Warts**	☐ **Change in bowel habits**	☐ **Dysphagia**	☐ **Inguinal/Femoral hernia**
☐ **Colon/Rectal cancer**	☐ **Melena**	☐ **GERD / Reflux**	☐ **Umbilical hernia**
☐ **Colitis / Crohn's refractory to medical management**	☐ **Heme + stools**	☐ **Nausea / Vomiting**	
☐ **Diverticulitis**	☐ **Visible blood in stool**	☐ **Diaphragmatic / Hiatal hernia**	
☐ **Fecal Incontinence**	☐ **Abdominal pain**	☐ **Inflammatory Bowel Diseases: Crohn's / Ulcerative colitis**	
☐ **Hemorrhoids**	☐ **Diarrhea**	☐ **Abnormal Liver Tests**	**Other**
☐ **Rectal Prolapse**	☐ **Constipation**	☐ **Jaundice**	☐ **Abnormal x-rays: please send copies of x-rays**
☐ **Pruritus ani**	☐ **Irritable bowel syndrome**	☐ **Hepatitis**	
	☐ **Unexplained weight loss**	☐ **Pancreatitis**	

Referring Physician Signature	**Date**	**Time**

For official use only:

Date received: ____/____/____ Date faxed back to provider: ____/____/____ Initials: _____ Time: _____