

Mandatory Lubbock Gastroenterology (GI) referral form

This form must be legible and fully completed for your referral to be processed

Patient information

Patient's full name: _____ DOB: _____

Male: Female: Primary language: _____ Race: _____

Patient address: _____ City: _____ State: _____ ZIP code: _____

Parent/Guardian full name: _____ DOB: _____

Relation to child: _____ Mom: Dad: Other: Contact number: _____

Emergency contact: _____ Contact number: _____

Name of previous GI doctor (if applicable): _____

Primary insurance: _____ Policy #: _____

Secondary insurance: _____ Policy #: _____

Referring physician/Primary care physician (PCP) information

Referring provider's full name: _____ NPI: _____

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

Office number: _____ Fax: _____

PCP full name: _____ (If different from referring provider)

Reason for referral

Abdominal pain Blood in stool Celiac disease Constipation GERD Failure to thrive/Poor growth Diarrhea

Inflammatory bowel disease Liver disease Short gut Pancreatitis Other: _____

To facilitate an efficient consultation for your patient, the following must be attached:

- Growth charts (required for all referrals)
- Current labs
- Relevant imaging reports
- Progress notes specific to referral diagnosis
- Copy of insurance card (front and back)

If this is an **urgent referral**, please call our specialty clinic directly.

Use our paperless portal to send referrals! epiccarelink.cookchildrens.org.

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