# Referral Form To Be Filled Out By Physician Only:

Dear Doctor, Thank you for referring your patient to our Gastroenterology facility. Please note that only complete referrals will be accepted (please see attached referral form). Referrals must include reason for the referral to our specialist, a consult note/ medical history along with current medications and dosage. In addition, any stomach related diagnostic testing or blood work can be attached.

| | |
|---|---|
| Patient Name: | Insurance Carrier/ID: |
| Date of Birth: | Contact #: |

| | |
|---|---|
| Referring MD: | Phone: |
| Address: | Fax: |

•Reason for Referral:

_____

_____

_____

• Medical Problem List:

_____

_____

_____

• List of all current pain medications, dosage and treatments:

_____

_____

• Please attach all medical diagnostic imaging.

**Check all that applies:**

| | |
|---|---|
| Atypical Chest pain | Ulcerative Colitis |
| Functional Dyspepsia | Pelvic Pain |
| Dysphagia | Rectal Pain |
| Reflux | Chronic Abdominal Pain |
| Swallowing Disorder | IBS- Diarrhea, Constipation, Mixed |
| Vomiting | Chronic Constipation |
| Nausea | Chronic Diarrhea |
| Chrohns Disease | Pelvic Floor Dysfunction |
| IBD | Fecal Incontinence |
| GI Malignancies | Motility Issues |
| Other Functional GI Disorder | Other: |

Only referrals containing all of the above information will be accepted. Please complete the above information and fax along with the referral letter and relevant reports to 718-479-1014. Thank you for your referral to Liberty Colonoscopy Center. All Diagnostic imaging and reports will be faxed to you when the patient is consulted at our facility. Thank you for your referral.