

Gastroenterology Referral Documentation

Patient Information

Name

Date of Birth

Gender

Contact Details

Patient ID / MRN

Referring Practitioner

Provider Name

Facility/Practice

Contact Details

Referral Details

Reason for Referral

Urgency

Specific Questions to Gastroenterologist

Clinical Summary

Relevant Medical History

Current Medications

Allergies

Relevant Examination/Lab Findings

Attachments

List of Attached Documents or Reports

Signature

Referring Practitioner Signature

Date