Iowa Specialty Hospital
Gastroenterology
1316 South Main Street
Clarion, Iowa 50525
(P) 515-532-9310 opt # 2
(F) 641-450-1317

GI Referral Form

Date: ____________________

Location (Please check one): Belmond Clarion Humboldt Fort Dodge Webster City

Reason for referral (Circle one): EGD/Colonoscopy EGD Only Colonoscopy Only

Diagnosis: Peg Tube Bravo PH Placement Capsule Endoscopy

______________________________ **Breath Test**: Lactose Fructose Sucrose Lactulose

Scope Follow-up (Complete sections A, C, & D)

Section A: Patient Information

Patient Name: _________________________ Date of Birth: _____/_____/______ Male Female

Previous Names: ____

Patient Address: ____

City: ______________________________ State: ____________ Zip Code: _______________________

Patient Phone: ____(home____work____cell____)

May we leave a Voice Mail or Text Message? Yes No

E-mail address:

Section B: Referring Provider Information

Referring Provider: ____

Provider Address: ____

Provider Phone Number: ___________________________ Fax: ________________________________

Section C: Patient History

Is the patient on any type of blood thinner? Y N Can they hold them for their procedure? Y N

Type: _____________________________ Prescribing Physician: _______________________________

*****Please attach any available patient demographics, up-to-date insurance cards, most current lab work, relevant imaging and diagnostic reports, and the patient's last visit note. Fax this sheet and any of the above listed data to the highlighted fax number listed at the top of this page*****

Section D: Insurance

Primary _________________________________ Secondary ___________________________________

Policy Holder ___________________________ Relationship to Patient ___________________________

Policy Holder ID #____

Date of Birth: _____/_____/______ Social Security # __________-__________-___________

Phone Number: ____

REV 8/30/2022