REQUEST FOR CONSULTATION OR TRANSFER OF CARE

BLANK Pediatric Gastroenterology Clinic
1215 Pleasant St.,Suite 600, Des Moines, IA 50309
Ph: (515) 241-6542

Referring Provider:

DX/Reason for Request: _____

_____ Consult only and return patient
_____ Transfer for management of this particular problem only and return patient upon diagnosis or treatment
_____ Please call if transfer to another provider becomes necessary
_____ Schedule any required pre-op exam with our office
_____ **Records available in Epic.**
_____ **FAX RECORDS TO** Gastroenterology (515) 241-8789

INFORMATION NEEDED: ☐ Growth Chart ☐ Laboratory Studies ☐ X-Ray Film or CD ☐ Other (see attached) ☐ Office Notes ☐ Current Treatment Plan ☐ Procedures

Clinical/Clerical Staff:

******INTERPRETER NEEDED?:*** ☐ Yes ☐ No Language_____

PATIENT: _____ **DOB:**_____ M F
(First) (MI) (Last)

Social Security # of Patient_____-_____- _____

Address: _____

_____

Home Ph:_____ Daytime Ph: _____

DAD / Domestic Partner: Name:_____(W)_____(cell) _____

MOM / Domestic Partner: Name:_____(W)_____(cell) _____

BILLING: (Responsible Party) Name: _____
(First) (MI) (Last)

Billing: DOB:_____SS #:_____-_____- _____

INSURANCE: _____ ****PLEASE SEND COPY OF CARD****

Group #: _____ Policy #:_____

XIX or MEDIPASS# _____ Insurer:_____

From DOS thru_____/Global

Secondary Insurance:_____ ****PLEASE SEND COPY OF CARD****

Group #:_____Policy #: _____

PRIMARY PROVIDER: _____ Phone:_____
(Primary Provider is listed on insurance screen)

Fax: _____

REFERRING PROVIDER: _____
(Referring Provider is listed on appointment screen)

Phone:_____**FAX:**_____**Contact:** _____

CLINIC ADDRESS: _____