Pediatric Gastroenterology Referral Form

pediatrix

GASTROENTEROLOGY
OF THE ROCKY MOUNTAINS

Please fax referral to 303-790-1989.

Please include clinic notes, labs, and other related records with the referral.
Please check desired location (if applicable)

❒ **Presbyterian St. Lukes**
1601 E. 19th Ave.
Suite 3550
Denver, CO 80218
Phone: 303-790-1515

❒ **Avista Adventist Hospital**
90 Health Park Dr.
Suite 390
Louisville, CO 80027
Phone: 303-790-1515

❒ **Lone Tree**
10465 Park Meadows Dr.
Suite 201
Lone Tree, CO 80124
Phone: 303-790-1515

❒ **St. Francis Hospital Colorado Springs**
6011 E Woodmen Rd.
Suite 115
Colorado Springs, CO 80923
Phone: 303-790-1515

❒ **West Littleton Health Center**
9670 W Coal Mine Ave.
Suite 200
Littleton, CO 80123
Phone: 303-790-1515

❒ **Castle Rock Adventist Hospital**
2352 Meadows Blvd.
Suite 300
Castle Rock, CO 80109
Phone: 303-790-1515

DATE OF REFERRAL: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Guardian Name: _____ Address: _____

City: _____ Zip: _____Email: _____

Phone: _____ Alt Phone: _____
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INSURANCE INFORMATION

Insurance: _____ ID#: _____Group #: _____

Policy Holder: _____ DOB: _____ Relationship to Pt. _____

REFERRING PROVIDER

Referring Provider: _____NPI: _____ Medicaid TPI: _____

Phone: : _____Fax: _____

DESIRED SCHEDULING TIME FRAME FOR REFERRAL

Routine: _____ Urgent: _____

SERVICES REQUESTED

❒ Pediatric Gastroenterology consultation
❒ Other _____
_____
_____

❒ Gastroesophageal reflux
❒ Constipation/encopresis
❒ Abdominal pain
❒ Ulcerative colitis
❒ Crohn's disease
❒ Celiac disease
❒ Ulcers
❒ Food allergies

❒ Polyps and rectal bleeding
❒ Vomiting
❒ Diarrhea
❒ Liver problems
❒ Weight loss
❒ Failure to thrive
❒ Irritable bowel syndrome

Additional comments (if applicable): _____

Thank you for the opportunity and privilege to care for your patient.