



**SUNY**  
**DOWNSTATE**  
Medical Center

University Hospital of Brooklyn  
College of Medicine  
School of Graduate Studies  
College of Nursing  
College of Health Related Professions

Department of Medicine  
Division of Gastroenterology & Hepatology

**GI Consults/Procedures**

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**Demographic Data:**

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Gender \_\_\_\_\_  
Address \_\_\_\_\_ Phone (H) \_\_\_\_\_  
\_\_\_\_\_ (W) \_\_\_\_\_  
SS# \_\_\_\_\_ SUNYHistory # (if applicable) \_\_\_\_\_  
Insurance \_\_\_\_\_

**Clinical Information**

**Referring Physician:**

\_\_\_\_\_  
Name of contact person in Referring Office

Office phone \_\_\_\_\_ Pager \_\_\_\_\_

Fax Number \_\_\_\_\_

Referring Physicians specialty: \_\_\_\_\_

**Type of visit requested:**

Urgent \_\_\_\_\_ < 2 weeks (Give reason)      Non-Urgent \_\_\_\_\_ > 2-4 weeks

Reason for referral:

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**Has the patient been evaluated by a gastroenterologist in the past? Y / N ( if yes, please enclose records)**

**If yes, what diagnosis was made?** \_\_\_\_\_

Laboratory Data (if available)

**Biopsy results** \_\_\_\_\_

**Tumor Markers?** \_\_\_\_\_

**CBC** \_\_\_\_\_

**Please send copies of other pertinent labs, endoscopy or X-ray data obtained to date.**

**Thank You for allowing us to participate in the care of your patient.**