Print

Reset Form Fields

Children's Gastroenterology Referral Form

Please fax referrals to: 843-792-7332
Please call Children's Services at: 843-876-0444, Option 1
to schedule the appointment & update demographics

Referring MD:_____ Contact: _____Contact Phone:_____

Patient's Name:_____ DOB _____ MRN _____

Parent's Name:_____ Phone numbers: _____

PLEASE NOTE: Faxing the referral without contacting Children's Services at above number first will result in a delay in scheduling the appointment.

1. **Has this patient seen a Peds GI specialist in the past?**
   ___Yes (please attach report or have parent obtain and fax) ___No

2. **Urgent Referral (Please call 843-792-5021 to discuss patient with an MD)**

3. **Reason for Referral (check all that apply):**
   - ___ Abdominal pain ___ Constipation
   - ___ Diarrhea
   - ___ FTT/Poor Growth
   - ___ Feeding problems/digestive problems supplements / formula
   - ___ Reflux/GERD (Include medication history)
   - ___ Dysphagia: Aggravating factors and relieving factors: _____
   - ___ Eosinophilic / Allergy Issues: (Fax allergy testing results)
   - ___ Blood in Stool / Rectal Bleeding
   - ___ Elevated Liver Enzymes / Jaundice
   - ___ Pancreatitis
   - ___ Inflammatory Bowel Disease: Ulcerative Colitis ___ / Crohn's Disease ___
     with weight Loss: ___ yes / ___ no
     (If patient has known diagnosis, please provide all previous records and pathology reports
   - ___ G-Tube / J-Tube / Management of Feedings (Fax most recent weight and heights)
     Where was the G-Tube or J-Tube placed _____
     Current Formula and feeding Schedule _____

4. **Please include the following information with your referral:**
   - **Growth Chart**
   - Insurance information (Name of Policy, Group number, Subscriber)
   - Demographic information including all contact phone numbers
   - Medications already used for this problem
   - Clinic notes as specified above.

5. **Summary of your concerns leading to this referral**:_____

   _____

   _____