ORLANDO HEALTH®
Digestive Health Institute

Center for Advanced Endoscopy, Research and Education (CARE)

Dr. Ji Young Bang
Dr. Robert Hawes
Dr. Udayakumar Navaneethan
Dr. Shyam Varadarajulu

LINE UP PATIENT I.D. LABEL HERE

PATIENT REFERRAL FORM

Referring Dr. _____ Date of referral: _____

Contact Name: _____ Phone: _____ Fax: _____

Primary Care Doctor: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Street: _____ City: _____ St: _____ Zip: _____

Phone: _____ Alt: _____ Cell: _____

Patient Email Address: _____

Primary Insurance: _____

Policy: _____ Group: _____ Phone: _____

Secondary: _____ Policy: _____

Please make sure you fax the required records by checking each appropriate box

☐ Patient Demographics ☐ H&P ☐ Pathology reports ☐ CAT scans/MRI/MRCP/Ultrasound ☐ PIT/INR
☐ Lab Work (LFTs, CA 19-9, Amylase, Lipase, Creatinine) ☐ Endoscopy reports ☐ Medication List

Please select requested procedure(s)

☐ Endoscopic Ultrasound ☐ ERCP ☐ EGD ☐ RFA (radio-frequency ablation) ☐ POEM ☐ GPOEM
☐ Double Balloon Enteroscopy ☐ Colonoscopy ☐ Endoscopic Mucosal Resection (EMR) ☐ Dilation
☐ Stent Placement ☐ Complex IBD Management ☐ Other: _____

Diagnosis/Indication for Procedure in WORDS (VERY IMPORTANT):

_____

Medical History (Please complete relevant portions):

History of gastric bypass, Billroth or Roux-en-Y: ☐ **Yes** ☐ **No** If **yes**, which surgery: _____

COPD/Emphysema: ☐ **Yes** ☐ **No** Home Oxygen: ☐ **Yes** ☐ **No** Obstructive Sleep Apnea: ☐ **Yes** ☐ **No**

Cirrhosis: ☐ **Yes** ☐ **No** CPAP Machine: ☐ **Yes** ☐ **No** If on CPAP, please bring machine with you to Hospital.

Prior anesthesia challenges: ☐ **Yes** ☐ **No** If yes, please specify challenge: _____

Medications Allergies: _____

Blood Thinners: ☐ **Yes** ☐ **No** If yes, circle one or specify: ☐**Coumadin** ☐**Plavix** ☐**Aspirin** ☐**Other** _____

Patient's Cardiologist: _____ Phone: _____

Diabetes: ☐ **Yes** ☒ **No** If yes, what medications: _____

Other Medications: _____

_____

Please Fax this and other relevant records to: (321) 843-6295

If you need to mail medical records, please mail to:
Digestive Health Institute, 1335 Sligh Blvd, MP 38, Orlando, Fl 32806

If you have any questions, please contact our office at Tel: (321) 842-CARE (2273)

COMMUNICATION ASSISTANCE PROVIDED (Please Print)		
QUALIFIED INTERPRETER	**QUALIFIED BILINGUAL TEAM MEMBER**	**ASSISTING VISUALLY IMPAIRED**
Team Member Name & I.D.: _____	Team Member Name & I.D.:	Team Member/Reader Name & I.D.:
Agency/Interpreter Name and/or I.D.: _____	_____	_____
☐Video remote ☐Tel ☐In-person Language: _____	Language: _____	Other: _____