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

ORLANDO HEALTH DIGESTIVE HEALTH INSTITUTE
Center for Advanced Endoscopy, Research and Education (CARE)

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: ________________________ SSN: ____________

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: ________________________________

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

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

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