ROCKFORD GASTROENTEROLOGY ASSOCIATES

Patient Referral Form

RGA Fax: 815-226-4948

Date: _____

☐ Consult ☐ Colonoscopy (Consult if determined necessary)

Patient Name: _____

Patient DOB: _____

Patient Phone: _____

Address: _____
_____

Patient SSN: _____

Insurance: _____
_____

Collaborating MD for NP/PA _____

Referring Dr. _____

MD Phone: _____

MD Fax: _____

Referring Physician Hospital Preference:

OSF/SAMC _____

SAH _____

RMH _____

____ First Time Colon____ Repeat Colon

____ Unknown

☐ Abd Mass	☐ Colitis	☐ Fm Hx Colon Ca	☐ Loss of appetite
☐ Abd Pain	☐ Constipation	☐ Fecal Incont	☐ Nausea
☐ Abn LFT's	☐ Crohn's	☐ Gas	☐ Polyp
☐ Abn X-ray	☐ Diarrhea	☐ GERD/Hrtbrn Reflux	☐ Rectal bleed
☐ Anemia	☐ Diverticulitis	☐ Hemorrhoid	☐ Rectal Pain
☐ Bloating	☐ Dyspepsia	☐ Hepatitis	☐ Screening Colon
☐ Blood in stool	☐ Dysphagia	☐ Hemoccult +	☐ Vomiting
☐ Chg in bowel habits	☐ Epigastric Pain	☐ Hiatal Hernia	☐ Weight Loss
☐ Chest pain	☐ Esophagitis	☐ Indigestion	

For RGA Use Only

Information

LFT's & Labs:

Faxed _____

Mailed _____

Pt to bring _____

Xrays _____ Loc _____

Patient to bring X-ray _____

Disposition

☐ Spoke with patient or _____

☐ Spoke with referring office

Date: _____

Time: _____

Apt. Type: _____

Location: _____

RGA Dr. _____

Signed: _____

Since we have not seen your patient, we have not reviewed records or made any diagnosis