UVA Digestive Health Clinic
1215 Lee Street, Charlottesville, VA
22908 Phone: (434) 243-3090
Fax: (434) 244-9445

NEW PATIENT REFERRAL/CONSULTATION

Please note, DHC will only schedule appointment with patient after all requested information is received.

Faxing instructions: Fax completed form (as page 1) with required medical records to 434-244-9445.

PATIENT INFORMATION **UVAHS MRN (*if known*):**

LAST NAME:		FIRST NAME:		MIDDLE NAME:
PRIMARY PHONE:	ALTERNATE PHONE:		SEX: F ☐ M ☐	BIRTH DATE:
RACE:	STREET ADDRESS:			
CITY:		STATE:		ZIP:

PRIMARY DIAGNOSIS:________________________________

CHECK SYMPTOMS:

HEPATOLOGY	INTERVENTIONAL	LUMINAL/GENERAL GI
☐ Elevated liver enzymes ☐ NASH/Fatty liver disease ☐ Liver mass/liver lesion ☐ Viral hepatitis ☐ Cirrhosis ☐ Other _____________	☐ Pancreatitis ☐ Pancreatic cyst ☐ Pancreatic cancer ☐ Biliary disease ☐ Bile duct stones ☐ Colon polyps	☐ Anemia ☐ Chronic abdominal pain Constipation ☐ Diarrhea ☐ Clostridium difficile ☐ IBS ☐ GI bleeding ☐ Nausea/vomiting ☐ Weight loss ☐ Other______________
ESOPHAGUS	**INFLAMMATORY BOWEL DISEASE**	
☐ GERD ☐ Barrett's esophagus ☐ Eosinophilic Esophagitis (EoE) ☐ Dysphagia ☐ Achalasia/ Motility	☐ Crohn's disease ☐ Pouchitis ☐ Ulcerative Colitis	

SPECIFIC QUESTIONS(S) TO BE ADDRESSED____

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THE FOLLOWING RECORDS MUST BE RECEIVED BEFORE SCHEDULING THE PATIENT:

- Last 3 office notes
- Most recent labs
- GI procedure/ pathology reports from the last 10 years (colonoscopy, EGD, capsule endoscopy, liver biopsy, etc)
- Abdominal reports/ swallow reports from the last 2 years

Interpreter Needed? YES ◯ NO ◯ If yes, which language (be specific)? ______________________________

REFERRING PHYSICIAN INFORMATION		
PHYSICIANS NAME:		
PRACTICE NAME:		
STREET ADDRESS:		CITY, STATE, ZIP
PHONE:	FAX:	REFFERING CONTACT NAME: