

MUSC GENERAL GASTROENTEROLOGY REFERRAL REQUEST FORM

Phone: **843-792-6982**
 Fax: **843-876-4717**

Please note that referrals are reviewed within 5 business days of receipt. This timeframe excludes weekends and holidays.

Please fax this completed referral form with all pertinent GI clinic notes, procedure and pathology reports, labs, and imaging to the MUSC GI Access Center at the fax number listed above.

Referring Provider Information

Requesting Provider:	Date:
Hospital / Office Name:	
Office Address:	
Office Phone:	Office Fax:
Office Contact Name:	

Patient Information *Please provide a copy of the patient's insurance card front and back.*

Patient Name:	DOB:	
Address:		
Home Phone:	Mobile Phone:	Email:
Primary Insurance:	Member ID #:	
Secondary Insurance:	Member ID #:	
Diagnosis including ICD10 code for consult or procedure referral:		

Referral Priority

- Routine
- First Available
- Urgent

Reason for Referral *The patient may require a pre-procedure clinic consult prior to scheduling.*

<input type="checkbox"/> General GI Clinic Evaluation Comments:			
<input type="checkbox"/> Colonoscopy	<input type="radio"/> Screening	<input type="radio"/> Surveillance	<input type="radio"/> Diagnostic
<input type="checkbox"/> Upper Endoscopy (EGD) Comments:			
<input type="checkbox"/> EndoFLIP			
<input type="checkbox"/> Motility Studies: <ul style="list-style-type: none"> <input type="radio"/> Esophageal Manometry Study ONLY <input type="radio"/> Esophageal Manometry with 24-hr pH motility study <input type="radio"/> Esophageal 96-hr pH motility study (BRAVO) <input type="radio"/> Anorectal Manometry 			
PLEASE NOTE: IF A PATIENT IS INTENDED TO HOLD THEIR PPI PRIOR TO MOTILITY STUDIES, THIS MUST BE INDICATED HERE. <input type="checkbox"/> HOLD PPI FOR DAYS PRIOR TO MOTILITY STUDY			