

Duke Gastroenterology Referral Form



Phone **919-684-6437**

Fax **919-479-2664**

For referrals within Duke Health, submit referral requests via MaestroCare.

Providers can submit referrals through Duke MedLink. MedLink is a secure, web-based application that allows referring providers quick and convenient read-only access to view patients' medical records, place orders and referrals, and send secure messages to Duke physicians. View more information about Duke MedLink at Physicians.DukeHealth.org/MedLink

Referral Requests

Please fax this completed referral form with all pertinent GI clinic notes, procedure and pathology reports, labs and imaging to the Duke GI Access Center at 919-479-2664. Your patient will be contacted after this information is received. Duke Gastroenterology can provide direct to procedure scheduling depending on the requested service and patient's health history.

Referring Provider Information

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

Patient Information *Please provide a copy of insurance card front and back*

Patient Name:		Date of Birth:	
Address:			
Home Phone:	Mobile Phone:	Email:	
Primary Insurance:	Member ID #:		
Secondary Insurance:	Member ID #:		
Diagnosis including ICD 10 code for consult or procedure referral:			

Referral Priority

☐ Routine ☐ Urgent

Referral for GI Clinic Evaluation

- ☐ General GI
- ☐ Esophageal ☐ Motility testing ☐ Barrett's esophagus
- ☐ Pancreatic/Biliary ☐ Biliary diseases ☐ Chronic pancreatitis ☐ Abnormal imaging
- ☐ Hepatology
- ☐ Inflammatory bowel disease
- ☐ Small bowel
- ☐ Pre-transplant evaluation ☐ Post-transplant care ☐ Liver ☐ Small bowel



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Referral for Colonoscopy *The patient may require a pre-procedure clinic consult before scheduling.*

Submit patient's last history and physical, including medications and allergies.

- ☐ Colonoscopy (Select prep option) ☐ Screening ☐ Surveillance ☐ Diagnostic

Patient Information *Please select to determine bowel preparation.*

The patient's medical history includes:

- ☐ Heart failure ☐ Electrolyte imbalance ☐ Kidney disease – renal insufficiency or dialysis
☐ Constipation ☐ History of poor bowel prep

Referral for Upper Endoscopy (EGD) *The patient may require a pre-procedure clinic consult before scheduling.*

- ☐ Upper Endoscopy (EGD)

Comments: _____

Referral for Advanced Endoscopic Procedure(s) *The patient may require a pre-procedure clinic consult before scheduling.*

- | | |
|--|---|
| ☐ ERCP | ☐ Double balloon enteroscopy |
| ☐ Upper EUS | ☐ Video capsule endoscopy |
| ☐ Lower/rectal EUS | ☐ POEM |
| ☐ Advanced Polyp Management | ☐ TIF |

Recent Radiology was performed at: _____

Referrals for Non-Endoscopic Procedures

- ☐ Esophageal Manometry Study (CPT 91010)
☐ Esophageal manometry with 24-hour impedance and pH study (CPT 91010/ 91038)

Please note: esophageal testing will be performed off all anti-secretory therapy (Patients will be instructed to hold proton pump inhibitors for 7 days and H2RA medications for at least 2 days.) For testing ON anti-secretory therapy please specify reason(s):

- ☐ Anorectal manometry (CPT 91120 / 91122)
☐ Lactulose hydrogen breath test - SIBO (CPT 91065)
☐ Helicobacter pylori breath test (CPT 78267 / 78268)
☐ Hemorrhoid banding - submit colonoscopy or flexible sigmoidoscopy report (performed within 3 years) with referral
☐ Fibroscan
☐ Pancreatic function test

Provider signature and NPI are required for motility studies and breath tests. Stamped signatures are not accepted.

Provider's Signature: *required* _____

NPI: _____

If page two is blank, do not fax.

