LOMA LINDA UNIVERSITY
HEALTH CARE

Referral Form
Pediatric Gastroenterology

Scheduling Line: 909-558-3904
Fax: 909-651-4257

Patient Information	
Does this patient live with someone other than the legal guardian? □ No □ Yes, relationship: _____	
Patient Name:	Date of Birth:
Parent/Guardian:	Parent/Guardian Cell Phone:
Insurance:	Home Phone:

1. Please select the type of referral: □ STAT □ Urgent □ Routine
If Stat or Urgent, please call our doctor-to-doctor line (909) 558-0099

2. Is this referral for a second opinion? □ **No** □ **Yes**

3. Please describe the patient's chief complaint and *include onset and frequency:*_____

_____

Reason for referral:

□ Abdomonial Pain	□ Growth Failure
□ Constipation	□ Jaundice
□ Diarrhea	□ Vomiting
□ GERD	□ Weight Loss
□ GI Bleed	□ Other

Work up done to date:

□ CBC	□ Stool OB
□ CHEM 18	□ Stool O&P
□ CT Scan-Abdominal	□ U/A
□ CT Scan-Head	□ UGI
□ ESR	□ UTZ
□ Stool C&S	□ Other

To optimize appointment scheduling, please provide the following by FAX to 909-651-4257

- This completed form
- Medical records related to the chief complaint
- A copy of the patient's insurance card
- If authorization is required, was authorization submitted? □ **Yes** □ **No** □ **Not Applicable**

Referring Provider Information

Provider Name: Address: City, State, Zip: Phone: Fax:	OR Provider Stamp

***Please notify the patient to call our Scheduling Line to make an appointment: 909-558-3904.**