

## Fax completed form with supporting documents to 855-813-0240

Please include: Insurance card copy, demographics and relevant clinical notes.

\*\* Failure to include this may cause a delay in processing.

## GASTROENTEROLOGY AND HEPATOLOGY SPECIALISTS

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> C. Gregory Albers, MD | <input type="checkbox"/> William Karnes, MD       | <input type="checkbox"/> Nimisha Parekh, MD   | <input type="checkbox"/> Marvin Singh, MD       |
| <input type="checkbox"/> Lydia Aye, MD         | <input type="checkbox"/> Robert Lee, MD           | <input type="checkbox"/> Sandra Park, MD      | <input type="checkbox"/> Neetika Srivastava, MD |
| <input type="checkbox"/> Ke-Qin Hu, MD         | <input type="checkbox"/> Christina Ling, MD       | <input type="checkbox"/> Carlos Saad, MD, PhD | <input type="checkbox"/> Robin Zachariah, MD    |
| <input type="checkbox"/> Lizhou Huang, MD      | <input type="checkbox"/> Hooshang Meshkinpour, MD | <input type="checkbox"/> Mark Salem, MD       | <input type="checkbox"/> First available        |

Date of referral: \_\_\_\_\_ Referring physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral coordinator: \_\_\_\_\_

**Referring MD signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PATIENT INFORMATION *(please print)*

Last: \_\_\_\_\_ First: \_\_\_\_\_ Date of birth (MM/DD/YY): \_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

First contact phone: \_\_\_\_\_ Second contact phone: \_\_\_\_\_

Email: \_\_\_\_\_

**PRIORITY**  Emergent (<48 hours)  Urgent (<72 hours)  Routine

**Diagnosis:** \_\_\_\_\_ **ICD-10:** \_\_\_\_\_

**OFFICE VISIT**  New patient consultation (99245)  Follow-up visit (99215)  Second opinion

## PROCEDURE

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Agile patency capsule (91299)          | <input type="checkbox"/> EGD with Bravo (43239, 91035, 00731)   | <input type="checkbox"/> Hepatic Elastography (91200, 0346T, 76705) |
| <input type="checkbox"/> Anal rectal manometry (91122)          | <input type="checkbox"/> EGD with capsule (43239, 91110, 00731) | <input type="checkbox"/> impedance (91010, 91038)                   |
| <input type="checkbox"/> Capsule endoscopy (91110)              | <input type="checkbox"/> EM/24-hr PH (91034)/(91010)            | <input type="checkbox"/> Screening, colonoscopy (45378, 00811)      |
| <input type="checkbox"/> Colonoscopy with biopsy (45380, 00811) | <input type="checkbox"/> Esophageal manometry (91010)           | <input type="checkbox"/> Screening, EGD (43235, 00731)              |
| <input type="checkbox"/> EGD with biopsy (43239, 00731)         |   |   |

## BREATH TEST

- SIBO test with Glucose solution (preferred)  H pylori test (urea) (83013, 83014, 99211)  
 Lactose intolerance test

**SPECIAL CONCERNS** *(if any are checked, please provide UCI Health anesthesia questionnaire)*

- CHF  Diabetes  Mobility issues  Renal failure  Sleep apnea

**UCI HEALTH**  
**H.H. CHAO COMPREHENSIVE DIGESTIVE DISEASE CENTER**  
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888-717-4463

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