

Pt. Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 MRN (If available): \_\_\_\_\_  
 Parent Name \_\_\_\_\_  
 Phone # \_\_\_\_\_ Preferred time:  8-12,  12-5,  after 5  
 Insurance:  Medicaid,  PPO,  HMO,  Self-pay / Other

Referring Provider Name: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Date of Request: \_\_\_\_\_

\*Please attach patient's demographics\*

**Step 1: When should patient be seen?**

- ASAP (≤ 24 hours)
  - For physicians new to Lurie Children's –Call the VIP Physician Hotline – **800.540.4131, Option 4**
  - For all other physicians, call the Lurie Children's GI Department Directly at **312.227.4200**
- Within 2 weeks
- > 2 weeks

**Step 2: Identify Chief Complaint**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> GI Symptoms                   | <input type="checkbox"/> Blood in Stool                       | <input type="checkbox"/> Feeding Intolerance        | <input type="checkbox"/> Liver Disease   |
| <input type="checkbox"/> Bloating/Abdominal Distention | <input type="checkbox"/> Dysphagia                            | <input type="checkbox"/> Hematemesis/Blood Loss     | <i>Note: If concern for a severe acute liver illness, please page liver fellow on call</i> |
| <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Encopresis                           | <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Gallstones * <sup>1</sup>   |
| <input type="checkbox"/> Vomiting                      | <input type="checkbox"/> Failure to Thrive/Poor Growth        | <input type="checkbox"/> Malabsorption Symptoms     | <input type="checkbox"/> Hepatitis B   |
| <input type="checkbox"/> Diarrhea                      | <input type="checkbox"/> Family History of Colon Cancer/Polyp | <input type="checkbox"/> Positive Celiac Panel      | <input type="checkbox"/> Hepatitis C   |
| <input type="checkbox"/> Constipation                  |   |   | <input type="checkbox"/> Elevated liver enzymes - obese patient                            |
| <input type="checkbox"/> GERD                          |   |   | <input type="checkbox"/> Elevated liver enzymes - non-obese patient                        |
| <input type="checkbox"/> Abdominal Pain                |   |   | <input type="checkbox"/> Neonatal Jaundice/Cholestasis * <sup>2</sup>                      |
| <input type="checkbox"/> Other                         |   |   | <input type="checkbox"/> Jaundice/elevated bilirubin - older child                         |
|  |   |   | <input type="checkbox"/> Other   |

\*1 - Consider referral to Pediatric Surgery unless medical indication for evaluation of Gall stones  
 \*2 - Please page nurse or liver fellow for appropriate timing of appointment

**Step 3: Info Requested for Each Referral**

- 1) Pertinent and Quick Patient History (1 – 2 sentences): (Please Print)  
 \_\_\_\_\_  
 \_\_\_\_\_
- 2) Questions referring provider wants answered by Specialist  
 \_\_\_\_\_  
 \_\_\_\_\_
- 3) Has patient been seen by pediatric GI in the past?  
 \_\_\_\_\_
- 4) Has the referring provider already spoken with a Lurie specialist about this referral?  
 \_\_\_\_\_
- 5) Is there a preferred provider to see the patient?  
 \_\_\_\_\_
- 6) Which location is preferred for the patient's appointment?  
 \_\_\_\_\_

**Ensure the following are submitted along with this Request for Service Order**

- |                   |                                       |
|-------------------|---------------------------------------|
| 1) Growth charts  | 3) Imaging (If Available)             |
| 2) Pertinent Labs | 4) External GI Opinion (if available) |

**Please submit this request along with records to KidsDoc Fax #: 312.227.9832**