



Motility and Functional Bowel Disorders Program Consultation Request

Thank you for your confidence to refer to the Motility and Functional Bowel Disorders Program. Please fax this completed form along with the required records to (414) 266-4709. This information is required to start the intake process.

Patient information	
Patient Name: _____	Provider Name: _____
Parent/Guardian Name(s): _____	
Patient Address: _____	Provider Address: _____
Date of Birth: _____	Phone Number: _____
Home Phone Number: _____	Fax Number: _____
Work Phone Number: _____	
Cell Phone Number: _____	
Insurance Carrier: _____	

Allergies: None _____

Weight: _____ kg Height _____ cm Developmental: Age Appropriate Delayed Age Level _____

Chief Complaint:

- | | | |
|---|--|---|
| <input type="checkbox"/> Achalasia | <input type="checkbox"/> Intestinal Pseudo-obstruction | <input type="checkbox"/> Hirschsprung's Disease |
| <input type="checkbox"/> Recurrent Vomiting | <input type="checkbox"/> Severe Recurrent Abdominal Pain | <input type="checkbox"/> Anorectal Disorders |
| <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Severe Constipation | <input type="checkbox"/> Other (must describe): _____ |

Please provide a comprehensive dictated synopsis of the patient history and specific questions regarding the patient management.

Current Medications: None _____

Other Underlying Medical conditions: None

- Kidney, Describe: _____
- Cardiac, Describe: _____
- Pulmonary, Describe: _____
- Bleeding Disorders, Describe: _____
- Diabetes, Describe: _____
- G Tube Feeds, Describe: _____
- Neurological Disorders: _____

The referral must be accompanied by the most recent and detailed clinic notes on any underlying medical conditions.

Please list previous Surgeries and Hospitalizations with corresponding dates:

The referral must be accompanied by all operative notes of surgeries, anesthesia records and hospitalizations.

Investigational procedures and diagnostics completed:
 EGD Colonoscopy Rectal BX KUB Barium Enema UGI/SBFT Abdominal/CT U/S Brain/MRI Spine/MRI

The referral must be accompanied by any report of ABNORMAL findings.

Relevant Labs completed:
Please send most recent chemistry, CBC, and clotting study results. Please send all relevant labs including thyroid function test, genetic studies, antineuronal antibody studies, cystic fibrosis test results.

Other (Describe): _____
The referral must be accompanied by report of any ABNORMAL findings.

Referring Provider Signature: _____ **Date/Time:** _____

OFFICE USE ONLY	
Date Received: _____	Clinician/MD: _____
<input type="checkbox"/> Referral Accepted Date of Appointment: _____	
<input type="checkbox"/> Referral Denied Reason: _____	
Referral Status Communicated to: _____ on: _____	
Comments: _____	

APPLY DT BARCODE STICKER
MD Referral Accepted DT 346
MD Referral Denied DT 9901