

GASTROENTEROLOGY REFERRALS

Thank you for choosing St. Peter's Health Medical Group Gastroenterology! We look forward to partnering with you. Completing and submitting this referral sheet will help us provide the highest quality patient care. Please attach demographic information to this form and **fax all information to us at 406-457-4339.**

Please let us know the reason for your referral:

☐ Urgent ☐ Routine

☐ Consult ☐ Colonoscopy

☐ Esophagogastroduodenoscopy (EGD)

Diagnosis: _____

Please ensure the corresponding information is enclosed:

- | | |
|--|--|
| ☐ Office notes | ☐ For colonoscopy or esophagogastroduodenoscopy (EGD) please include: |
| ☐ Medication and allergy lists | ☐ Signed/dated order from referring provider |
| ☐ Pertinent laboratory results and x-ray images | ☐ Previous procedure notes |
| ☐ Please advise if patient is: | ☐ Previous pathology reports |
| ☐ Diabetic | |
| ☐ Supplemental oxygen | |

Please push all images to PACs at St. Peter's Health or mail hard copy disk. Our providers will review all documents and imaging once received and your patient will be called to schedule.

Thank you again for choosing St. Peter's Health!

Best Regards,
St. Peter's Health Gastroenterology