General GI Referral Form

357 Flatbush Ave • Brooklyn, NY 11238
Ph (718) 230-3535 • Fax (718) 230-0596 • Alt Fax (718) 230-0390

SHIP TO:	❑ Patient's Home	❑ Provider's Office	❑ Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: ❑ M ❑ F	
Patient Address: (include apt. #)			City:	State:	Zip:
Home Phone:	Work Phone:		Cell Phone:	Primary Language:	

PHARMACY INSURANCEINFORMATION:

Primary Insurance Name:	Insured's SSN:	Patient ID#:
Rx BIN#:	Rx PCN#:	Rx Group#:

****Please include a copy of the front and back of the patient's pharmacy insurance card with this form****

PRESCRIBING PHYSICIAN INFORMATION:

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician DEA # :	Physician NPI #:	License #:

CLINICALINFORMATION:

Diagnosis: _____ ICD-10 Code: _____	❑ New start ❑ Continuation of therapy	Medication List:
Height: ❑in ❑cm Weight: ❑lbs ❑kgs	Allergies: _____	

MEDICATIONS TRIED AND FAILED:

Medication Name and Strength	Route	Frequency	Approx. Date Range Therapy Began and Stopped	Outcome
			____/____ to ____/____	
			____/____ to ____/____	
			____/____ to ____/____	
			____/____ to ____/____	

PRESCRIPTION INFORMATION: Please indicate DAW on the prescription for brand products.

****Please include an original prescription with this form or E-scribe a prescription to Kings Pharmacy****

❑ **LINZESS (linaclotide) PO daily #30 caps**
❑ **145 mcg PO daily** ❑ **290 mcg PO daily**
Refills: _____

❑ **DEXILANT (dexlansoprazole) PO daily #30 caps**
❑ **30 mg PO daily** ❑ **60 mg PO daily**
Refills: _____

❑ **XIFAXAN (rifaximin)**
❑ **200 mg** ❑ **550 mg**
Sig: _____
Quantity: _____
Refills: _____

❑ **PYLERA 3 caps PO QID after meals and at bedtime #120 caps**
Refills: _____

❑ **Other:**
Sig: _____
Quantity: _____
Refills: _____

PRESCRIBER SIGNATURE: **DATE:**