



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:	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Provider's Office	<input type="checkbox"/> Other:

PATIENT INFORMATION:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient Address: (include apt. #)			City:	State: Zip:
Home Phone:	Work Phone:	Cell Phone:		Primary Language:

PHARMACY INSURANCE INFORMATION:

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 #:

CLINICAL INFORMATION:

Diagnosis: _____ ICD-10 Code: _____	<input type="checkbox"/> New start <input type="checkbox"/> Continuation of therapy	Medication List: _____ _____ _____
Height: <input type="checkbox"/> in <input type="checkbox"/> cm Weight: <input type="checkbox"/> lbs <input type="checkbox"/> 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****

<input type="checkbox"/> LINZESS (linaclotide) PO daily #30 caps <input type="checkbox"/> 145 mcg PO daily <input type="checkbox"/> 290 mcg PO daily Refills: _____	<input type="checkbox"/> DEXILANT (dexlansoprazole) PO daily #30 caps <input type="checkbox"/> 30 mg PO daily <input type="checkbox"/> 60 mg PO daily Refills: _____
<input type="checkbox"/> XIFAXAN (rifaximin) <input type="checkbox"/> 200 mg <input type="checkbox"/> 550 mg Sig: _____ Quantity: _____ Refills: _____	<input type="checkbox"/> PYLERA 3 caps PO QID after meals and at bedtime #120 caps Refills: _____

Other:
 Sig: _____
 Quantity: _____
 Refills: _____

PRESCRIBER SIGNATURE:	DATE:
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