LOTSU DIGESTIVE
HEALTH & NUTRITION™

DZIFAA K. LOTSU, MD, MPH
Gastroenterology

840-842 West Adams Street
Chicago, IL 60607
Tel: 312-929-3140
Fax: 312-496-3272
www.lotsuhealth.com

NEW PATIENT/CONSULTATION REFERRAL FORM

In an effort to provide the best possible care for each patient please complete entire form and attach clinic notes, endoscopy reports, imaging reports, pathology, labs, and if recently hospitalized, a discharge summary. Thank you for your consideration!

PATIENT INFORMATION

Last name _____ First Name _____

DOB _____ Phone _____ Email _____

Gender _____ Address _____

Primary language of patient

○ English ○ Spanish ○ Polish ○ Other: _____

REASON FOR REFERRAL

- ○ Achalasia
- ○ Abdominal Pain
- ○ Anemia
- ○ Abnormal liver enzymes
- ○ Atypical chest pain
- ○ Anorectal Pain
- ○ Hematemesis
- ○ Acute Pancreatitis
- ○ Barrett's Esophagus
- ○ Constipation
- ○ Rectal bleeding
- ○ Chronic Pancreatitis
- ○ Chronic Cough
- ○ Chronic Diarrhea
- ○ GI Malignancy
- ○ Cirrhosis
- ○ Dyspepsia
- ○ Fecal Incontinence
- ○ Crohns' Disease
- ○ Hepatitis B
- ○ Dysphagia
- ○ IBS
- ○ Ulcerative Colitis
- ○ Hepatitis C
- ○ Esophagitis
- ○ Indeterminate colitis
- ○ NASH/NAFLD
- ○ Esophageal Motility
- ○ Diverticulitis
- ○ Autoimmune Hepatitis
- ○ Globus Sensation
- ○ Liver mass
- ○ H.pylori
- ○ Weight Loss/Nutritional Consultation

Additional Concerns/Comments: _____

_____

_____

Commerical Insurances Accepted at Lotsu Digestive Health and Nutrition Center
Please select and fax copy of insurance card

- ○ Aetna
- ○ AARP
- ○ BCBS
- ○ Cigna
- ○ Coventry
- ○ Harken Health
- ○ Healthlink
- ○ Humana (pending)
- ○ Medicare
- ○ PHCS Multiplan
- ○ Tricare (pending)
- ○ United Healthcare

LOTSU DIGESTIVE
HEALTH & NUTRITION™

DZIFAA K. LOTSU, MD, MPH
Gastroenterology

840-842 West Adams Street
Chicago, IL 60607
Tel: 312-929-3140
Fax: 312-496-3272
www.lotsuhealth.com

PROCEDURE REFERRAL ONLY

Last name _____ First Name _____

DOB _____ Phone _____ Email _____

Gender _____ Address _____

REASON FOR REFERRAL

Indication for procedure: _____

Date of last procedure: _____

Is patient on antiplatelets or anticoagulation? ○ Yes ○ No;

If so, can medication be held prior to procedure? ○ Yes ○ No (please call office)

○ EGD	○ Hemorrhoid Banding	○ Push Enteroscopy
○ Colonoscopy	○ Anoscopy	○ Pouchoscopy
○ Flexible Sigmoidoscopy	○ High Resolution Anoscopy	○ Other
○ Capsule Endoscopy	○ Ileoscopy	

_____

_____

_____

_____

REFERRING OFFICE

Referring Provider Name _____ Office Phone _____

Referring Provider Signature _____

Office Phone _____ Fax _____