REFERRAL FORM Patients with Crohn's or Ulcerative Colitis

Dr. Themistocles Dassopoulos, M.D.
3409 Worth Street, Suite 640
Dallas, Texas 75246

Phone: 469-800-7180
Fax: 469-800-7190

Date _____
Patient first, last name (print) _____
Gender ◯ Male ◯ Female DOB _____
Phone (home) _____ (cell) _____ (other) _____
Home Address _____ City, State, Zip _____

INSURANCE INFORMATION

Primary Insurance _____ ID # _____
Group #_____ Insurance # _____
Subscriber (policy holder) _____

Secondary Insurance _____ ID # _____
Group # _____ Insurance # _____
Subscriber (policy holder) _____

If patient's insurance requires insurance referral please obtain & send one week before patient's visit.

Referring Physician _____
Gastroenterologist _____ Primary Care Physician _____
Colorectal Surgeons _____ Other providers involved in care _____
Diagnosis ◯ Crohn's disease ◯ Ulcerative Colitis ◯ Celiac Disease ◯ Other _____
Referral Type ◯ Consult Only ◯ Screening Colonoscopy ◯ EGD ◯ Sigmoidoscopy ◯ Ileoscopy ◯ Pouchoscopy ◯ Chromoendoscopy
◯ Other _____

IMPORTANT Please fax/mail all of the following information below

- ◯ Physician records: **ALL** office visit notes
- ◯ Laboratory results: Prometheus labs/ blood results /stool results **ALL**
- ◯ Reports: colonoscopies/EGD's/pathologies /any procedure reports/imaging **ALL**
- ◯ Hospitalization Admission & discharge summaries, surgical operative reports- **ALL**
- ◯ Insurance: front & back insurance card/ insurance referral if necessary

Fax: 469-800-7190 Thank you for the referral!