

# CONSULTATION REQUEST

**Crohn's and Colitis Clinic**

Phone: 405-271-5428 ext 53424

**Patient Information**

**Name (print)** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**Phone: Home** \_\_\_\_\_ **Cell** \_\_\_\_\_  
**Home Address** \_\_\_\_\_

**Insurance Information**

**Insurance Company** \_\_\_\_\_ **Name of Insured** \_\_\_\_\_  
**ID #** \_\_\_\_\_ **Group #** \_\_\_\_\_  
**Member Services Phone #** \_\_\_\_\_  
**Authorization Required:**     Yes     No

**Referring Physician Information**

**Name (print)** \_\_\_\_\_  
**Office Phone:** \_\_\_\_\_ **Office Fax:** \_\_\_\_\_

**Diagnosis**

- Ulcerative Colitis**
- 556.0 Enterocolitis
  - 556.1 Ileocolitis
  - 556.2 Proctitis
  - 556.3 Proctosigmoiditis
  - 556.5 Left-sided
  - 556.6 Universal
  - 556.8 Other
  - 556.9 Unspecified

**Crohn's Disease**

- 555.0 Small Intestine
  - 555.1 Large Intestine
  - 555.2 Sm/Lg Intestine
  - 555.9 NOS
- Other**
- \_\_\_\_\_
  - \_\_\_\_\_
  - \_\_\_\_\_

**Current Therapy**

- Mesalamine
- Steroids
- Immunomodulators
- Biologics
- None

**Reason for Consultation**

- Active Disease
- Second Opinion
- Other \_\_\_\_\_

**Please mail or fax the following information (check off each item included):**

- \_\_\_\_\_ Reports from all colonoscopies, endoscopies, video capsule endoscopies or other GI procedures.
- \_\_\_\_\_ Physician records, including consultant reports.
- \_\_\_\_\_ Laboratory results: Blood tests, serologies, metabolite levels, stool specimens, pathology results, etc.
- \_\_\_\_\_ Hospitalization Admission & Discharge Summaries, Surgical Operative Reports.
- \_\_\_\_\_ Copy of front and back of patient's insurance card

*This form may be used as cover sheet. We ask you please limit faxes to 40 pages.*

**COURIER MAIL TO:**  
**OU IBD Program**  
**Attn: New Patient Appointments**  
**920 SL Young Blvd, WP 1345**  
**Oklahoma City, Oklahoma 73104**

**ONLINE SUBMISSION:**  
**www.oumedicine.com/ibd**

**FAXED SUBMISSION:**  
**(405) 271-5803**

*Thank You Very Much!*