Billings Clinic Gastroenterology
2nd Floor Gastroenterology
801 N 29th Street
Billings, MT 59101
Phone: 406-238-5796
Fax: 406-238-2763

Patient Name: _____ **Date of Birth:** _____ **Patient Phone:** _____

Reason for Consult: _____

Referring Provider: _____ **Provider Phone:** _____ **Provider Fax:** _____

Gastroenterology REFERRAL GUIDELINES

Please see guidelines/workup requirements

Send all Labs, images and medication list (Rx, OTC, Herbs, Supplements) must be current within 6 months

☐**Diarrhea**; Consider infectious stool tests as well as fecal calprotectin or fecal elastase; labs including CBC/CMP/TSH are required

☐**Abdominal Pain;** labs including CBC/CMP are required, Consider H pylori testing or imaging such as RUQ US or CT

☐**Elevated Liver Tests**; Baseline labs including CBC, CMP, PT/INR, Abdominal US with elastography(if fatty liver concerns) are required

☐**Constipation**; Abdominal XRAY, labs CBC/CMP/TSH, consider miralax and or fiber and or stool softeners before referring

☐**Dysphagia**;Esophagram, consider PPI

☐**Anemia**;labs such as CBC, iron panel + ferritin, B12/folate levels are required

☐**Unintentional Weight Loss**; CT A/P with contrast

☐ **Chronic GERD**; trial BID PPI for 6-8 weeks prior to referral

☐ **Chonic nausea and vomiting**; assess for chronic THC use, we request 6 month trial off of marijuana prior to GI consultation unless having other red flag symptoms (GI bleeding, unintentional weight loss etc)consider trial off of GLP-1 for 1-2 months prior to referral

PLEASE SELECT FROM THE PROCEDURE ORDERS BELOW

Direct procedures are subject to provider review which may result in an initial office visit

☐ **Direct Colonoscopy**

☐ **Direct EGD**

☐

☐

☐

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Referring provider signature required: _____ **Date:** _____

Please send referring provider notes, all Gastroenterology medical records including images and demographics sheet.

Date faxed: _____