Ann & Robert H. Lurie Children's Hospital of Chicago

GI / Hepatology Request for Service Order

Pt. Name:_____

DOB:_____

MRN (If available):_____

Parent Name_____

Phone #_____Preferred time: ☐ 8-12, ☐ 12-5, ☐ after 5

Insurance: ☐ Medicaid, ☐ PPO, ☐ HMO, ☐ Self-pay / Other

Referring Provider Name: _____

Practice Name:_____

Date of Request:_____

Please attach patient's demographics

Step 1: When should patient be seen?

☐ ASAP (≤ 24 hours)

- For physicians new to Lurie Children's –Call the VIP Physician Hotline – **800.540.4131, Option 4**
- For all other physicians, call the Lurie Children's GI Department Directly at **312.227.4200**

☐Within 2 weeks

☐> 2 weeks

Step 2: Identify Chief Complaint

☐ GI Symptoms
- ☐Bloating/Abdominal Distention
- ☐Nausea
- ☐Vomiting
- ☐Diarrhea
- ☐Constipation
- ☐GERD
- ☐Abdominal Pain
- ☐ Other

☐ Blood in Stool

☐ Dysphagia

☐ Encopresis

☐Failure to Thrive/Poor Growth

☐ Family History of Colon Cancer/Polyp

☐ Feeding Intolerance

☐ Hematemesis/Blood Loss

☐Inflammatory Bowel Disease

☐ Malabsorption Symptoms

☐Positive Celiac Panel

☐ Liver Disease

Note: If concern for a severe acute liver illness, please page liver fellow on call
- ☐ Gallstones *[1]
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Elevated liver enzymes - obese patient
- ☐ Elevated liver enzymes - non-obese patient
- ☐ Neonatal Jaundice/Cholestasis *[2]
- ☐ Jaundice/elevated bilirubin - older child
- ☐ Other

*1 - Consider referral to Pediatric Surgery unless medical indication for evaluation of Gall stones
*2 - Please page nurse or liver fellow for appropriate timing of appointment

Step 3: Info Requested for Each Referral

1) **Pertinent and Quick Patient History (1 – 2 sentences):** (Please Print)

_____

_____

2) **Questions referring provider wants answered by Specialist**

_____

_____

3) **Has patient been seen by pediatric GI in the past?**

_____

4) **Has the referring provider already spoken with a Lurie specialist about this referral?**

_____

5) **Is there a preferred provider to see the patient?**

_____

6) **Which location is preferred for the patient's appointment?**

_____

Ensure the following are submitted along with this Request for Service Order

1) Growth charts
2) Pertinent Labs
3) Imaging (If Available)
4) External GI Opinion (if available)

Please submit this request along with records to KidsDoc Fax #: 312.227.9832