Kootenai Clinic Gastroenterology
1919 Lincoln Way, Suite 415
Coeur d'Alene, ID 83814
208.625.4595 Phone
208.625.4596 Fax

KC Gastroenterology
Procedure & Consult Referral Form

K.R. Webb M.D. J.S. Goff M.D. G.S. Young, M.D. M.W. James, M.D. H.G. Preiksaitis, M.D.
Susan Hildebrandt N.P. Tim Doty P.A. Jim McMahon P.A.

Please complete the ENTIRE form so we are able to schedule your patient properly

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To: Dr. _____From: Dr._____ Today's Date:_____

Patient Name: _____ Phone Number:_____

Mailing Address:_____

Birthdate: _____/_____/_____ Has the patient seen us before? Yes/No Which Doctor? _____

Email: _____ Pharmacy: _____

Primary Insurance:_____ Secondary Insurance: _____

Emergency Contact:_____

Insurance referrals needs to be completed before procedures and office visits can be scheduled*

Please send all pertinent medical records so that we can schedule and evaluate the patient properly*

Referral For: ☐ EGD ☐ Dilation ☐ Colonoscopy ☐ Flexible Sigmoidoscopy

☐ EUS Upper/Lower ☐ ERCP ☐ Office Consultation

Diagnosis/Complaint: _____

Site Preferred: ☐ KH Specialty Procedures ☐ KC Endoscopy ☐ No Preference

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Please Circle "Yes" or "No"

Heart Problems: **Yes / No** If yes, what? _____

Endocarditis/Rheumatic Fever: **Yes / No** Hypertension: **Yes / No** Congestive Heart Disease: **Yes / No**

Respiratory Problems: **Yes / No** Heart Valve Abnormalities and/or Replacements: **Yes / No**

Kidney Problems: **Yes / No** If yes, what? _____ Renal Failure: **Yes / No** Diabetes: **Yes / No**

Colonic or Gastric Surgery: **Yes / No** If yes, what type? _____

Is The Patient Taking Any Of The Following? Please Circle "Yes" or "No"

Coumadin: **Yes / No** If yes, why? _____ Plavix: **Yes / No** If yes, why? _____

Blood Pressure Meds: Yes / No Diabetes Meds: Yes / No If yes, what? _____ ASA/NSAIDS: **Yes / No**

DOES THE PATIENT HAVE AN ALLERGY TO EGGS? _____ Is the patient taking: Pradaxa, Effient, or Xarelto? **Yes / No**

DOES THE PATIENT HAVE ALLERGIES TO ANY MEDICATIONS? Yes / No If yes, what type?_____
