

**SWEDISH DIGESTIVE HEALTH NETWORK**

Arnold Pavilion, 1221 Madison St., Suite 1220, Seattle, WA 98104  
T 206-215-8178 1-855-411-MyGi (6944) F 206-215-3525  
www.swedish.org/digestive



**REFERRAL INTAKE FORM**  
(To be completed by referring provider)

Date:

Referring Provider	
Referring Provider Name:	Patient's PCP
Clinic:	Clinic Contact:
Phone:	Fax:
Email:	Is this a self-referral?      Yes      No

Patient Information			
Name:		Female	Male
DOB:	Home Phone:	Cell Phone:	
Address:	City:	State:	Zip:
Interpreter Needed?    Yes    No	Language:	Work Phone:	
Primary Ins:	Ins. Contact:	Secondary Ins:	
ID:	Phone:	ID:	
Group:		Group:	

Referral Details:	
Diagnosis:	Symptoms:
Urgency: Emergent    1 week    2 weeks    Next Aval Appt	
Provider Preference?	First Available Provider:
Diagnostics required:	
Contact/Calls:	

Fax this form along with the following documents to Swedish Digestive Health Network **206-215-3525**  
**vH&P Referral Dictation    vMedication/Allergy List    vGI Procedure Reports    vLab Results    vPath Report    vEKG    vRad Reports: CT, MRI, US, HIDA, Chest x-ray**