SWEDISH IBD CENTER
T 206-215-6533 F 206-215-3525
swedish.org/IBD

SWEDISH
DIGESTIVE HEALTH
NETWORK
Extraordinary care. Extraordinary caring.SM

Inflammatory Bowel Disase
Referral Intake Form

(To be completed by referring provider)

Date: MRN:

Referring Provider	
Referring Provider Name:	Patient's PCP:
Clinic:	Clinic Contact:
Phone:	Fax:
Email:	

Patient Information			
Name:			☐ Female ☐ Male
DOB:	Home Phone:		Cell Phone:
Address:	City:	State:	Zip:
Interpreter Needed? ☐ Yes ☐ No	Language:		Work Phone:
Primary Ins:	Subscriber:		Secondary Ins:
ID:	Subscriber's DOB:		ID:
Group:	Subscribers SSI:		Group:

Referral Details:	
Diagnosis: ☐ **Crohns** ☐ **Ulcerative Colitis**	Symptoms:
Urgency: ☐ Urgent ☐ Routine	
Provider Preference?	First Available Provider:
Past GI providers (name/location):	

To help us best care for your patient, please tell us more about your patient's history:

Date diagnosed: _____

Distribution (small bowel, colon): _____

Medication Trials: ☐ Thiopurines ☐ Methotrexate ☐ Sulfasalazine/5-ASA ☐ Corticosteroid ☐ Antibiotics

Biologic Therapy: ☐ Remicade ☐ Humira ☐ Cimzia ☐ Tysabri ☐ Entyvio ☐ Stelara

History of other treatment: _____

History of abdominal surgery: _____

Last endoscopic evaluation: _____
(please include procedure AND pathology reports)

Last abdominal imaging (please include): _____

Please include most recent labs.

Fax this form along with the following documents to Swedish IBD Center **206-215-3525**

√H&P Referral Dictation √Medication/Allergy List √GI Procedure Reports √Lab Results
√Path Report √EKG √Rad Reports: CT, MRI, US, HIDA, Chest x-ray

Internal Use Only:

Appt. Date: Referrals Sent To: EPIC Number:
Clinic: Epic Number: CIN: