

IBD Clinic at North Union

**ECMC IBD Clinic Referral Form/Checklist**

30 North Union Road · Buffalo, NY 14221

Phone: **716-395-GIBD (4423)** · Fax: **716-898-5603**

**Patient Name:**

**Date of Birth:**

**Referring Provider Name/Contact:**

**Referral Reason:**

\_\_\_\_\_ Transition to Adult IBD Care

\_\_\_\_\_ New IBD Diagnosis

\_\_\_\_\_ Transition to IBD Specialty Care

\_\_\_\_\_ Suspected IBD Diagnosis

\_\_\_\_\_ Other:

**Please include the following with referral form:**

\_\_\_\_\_ Patient Demographics

 \_\_\_\_\_ Endoscopy Reports

\_\_\_\_\_ Progress Notes

 \_\_\_\_\_ Pathology Reports

\_\_\_\_\_ Medication List

 \_\_\_\_\_ Laboratory Studies

\_\_\_\_\_ Surgical Reports

 \_\_\_\_\_ Diagnostic Imaging