INTEGRIS
Nazih Zuhdi Transplant Institute

FOR AN APPOINTMENT PLEASE SEND REFERRAL TO:
INTAKE COORDINATOR
FAX: 405-713-7668 PHONE: 405-949-3349

PEDIATRIC GASTROENTEROLOGY REFERRAL FORM

❑ Dr. Michael Morris ❑ Dr. Maryam Shambayati

PATIENT INFORMATION

Name:_____DOB:_____
Address:_____
City/State/Zip Code:_____
Mother's Name/Phone:_____
Father's Name/Phone:_____

Referring Diagnosis:_____
Has patient seen Pediatric GI before? Yes_____No_____
If so, who?_____

Referring Physician Information

Name:_____MD/DO/PA-C/APRN-CNP
Office Address:_____
City/State/Zip:_____
Office Phone:_____Office Fax:_____
Office Contact Person:_____

INSURANCE INFORMATION

Primary Insurance _____
ID Number_____Group Number_____
Cardholder's Name_____DOB:_____
Secondary Insurance (if applicable)_____
ID Number_____Group Number_____
Cardholder's Name_____DOB_____

PLEASE INCLUDE WITH REFERRAL

LAB RESULTS-LAST 3 MONTHS
RADIOLOGY -ANY RESULTS OF ANY ULTRASOUNDS,MRI'S OR CAT SCANS DONE
OFFICE NOTES- ANY NOTE PERTAINING TO DIAGNOSIS