REQUEST FOR AUTHORIZATION OF REFERRAL TO GI FOR TREATMENT OF CHRONIC ABDOMINAL PAIN

Please complete this form and the standard referral form, attach supporting clinical documentation, and FAX to CPMG CUSTOMER SERVICE at 858 309-7977. CPMG cannot review your request without this information.

Name of referring Provider: ________________________________ **Referring Provider phone #**_________________

Member Name: _____________________ **Member ID#:** ___________________ **DOB:** _________ **Age**_____

Please check ALL that apply

1. Which, if any, of the following red flags apply to the patient? ☐ Isolated RUQ or RLQ pain ☐ Involuntary weight loss ☐ Growth retardation ☐ Frequent or bilious vomiting ☐ Marked diarrhea or hematochezia ☐ Protracted fever ☐ Anemia ☐ Jaundice ☐ Psychiatric illness ☐ Family hx of inflammatory bowel disease or celiac sprue ☐ Extraintestinal symptoms (arthralgia, skin rash) ☐ Abnormal physical exam ☐ None of the above	4. Does patient complain of pain alone? ☐ YES ☐ NO 5. Were CBC, ESR, Chem 12 panel, Hemoccult, U/A, KUB, consider abd. u/s all normal? ☐ YES ☐ NO 6. For which of the following environmental triggers did you recommend modification? ☐ food choices ☐ family dynamics ☐ food temperature ☐ school stressors ☐ sleep habits ☐ secondary gain
2. If patient suffers from dyspepsia and CBC, ESR, Chem 12 panel, Hemoccult, U/A, KUB, H Pylori Ab were all normal, did you place patient on a trial of antacids or acid suppression? ☐ YES ☐ NO If YES, was the trial effective? ☐ YES ☐ NO	7. Did you consider a trial of low-dose amitriptyline? ☐ YES ☐ NO If YES, was it effective? ☐ YES ☐ NO
3. If member complains of altered bowel movements and CBC, ESR, Chem 12 panel, Hemoccult, U/A, KUB, stool cultures, stool wbc were all normal, did you place patient on a trial of fiber supplements or non-stimulant laxative if constipated (eg Miralax)? ☐ YES ☐ NO If YES, was the trial effective? ☐ YES ☐ NO	8. Were any of the recommended treatments effective? ☐ YES ☐ NO 9. If not, are you requesting authorization for referral to **GI Biofeedback**? ☐ YES ☐ NO ***If your answer to #9 above is "NO", CPMG will review as a request for referral directly to GI.***

Please attach completed standard CPMG referral request form and all relevant clinical information to this form and FAX to CPMG CUSTOMER SERVICE at 858 309-7977. Failure to submit complete information will delay authorization decision.