WVU Medicine

Digestive Diseases ERCP Referral

PHONE: **304-293-4123** FAX: **304-293-2135** **PO Box 9161, Morgantown, WV 26506-8012**

Date of Referral: _____/_____/_____ **Please attach the most recent history and physical**

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

ADDITIONAL HISTORY

Is there a family history of GI cancer? ☐ **Yes** ☐ **No**

Indications: _____

Anticoagulation therapy: ☐ **Yes** ☐ **No**

If yes, please list medication: ☐ **Coumadin** ☐ **Aspirin** ☐ **Plavix** ☐ **Other:** _____

Can therapy be stopped 5-7 days prior to procedure? ☐ **Yes** ☐ **No**

Does patient have prosthetic device (i.e. heart valve) requiring antibiotic prophylaxis? ☐ **Yes** ☐ **No**

Can patient give consent? ☐ **Yes** ☐ **No**