WVUMedicine

Gastroenterology/Hepatology – ERCP Referral

PHONE: **304-598-4855** FAX: **304-598-6831** **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**