WVU Medicine

Gastroenterology/Hepatology Advanced Endoscopy Referral

PHONE: **304-293-7020** 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: _____

PROCEDURE REQUESTED

- ☐ **Cholangioscopy**
- ☐ **Cryoablation for Barrett's Esophagus**
- ☐ **Deep Enteroscopy**
- ☐ **Endoscopic Ultrasound (EUS)**
- ☐ **EUS Directed Gastrostomy ERCP (EDGE procedure)**
- ☐ **Endoscopic Full Thickness Resection (EFTR)**
- ☐ **Endoscopic Mucosal Resection**
- ☐ **Endoscopic Necrosectomy**
- ☐ **Endoscopic Retrograde Cholangiopancreatography (ERCP)**
- ☐ **Endoscopic Suturing**
- ☐ **Endoscopic Stenting and Bypass Procedures**
- ☐ **Per-oral Endoscopic Myotomy (POEM)**
- ☐ **Pseudocyst Drainage**
- ☐ **Radiofrequency Ablation**
- ☐ **Transoral Incisionless Fundoplication**
- ☐ **Other** _____

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** ☐ **Unsure**

If no or unsure, please provide contact information for prescribing provider: _____

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

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