Clarian Health
Methodist·IU·Riley

ERCP Referral Form

PATIENT

Name Patient Phone
Address
MRN (if available) SSN DOB
Alternate Contact/Relative Phone ( )
Patient Weight X-Ray Dye Allergy Yes No Latex Allergies Yes No
Patient Records Faxed to IU Yes No Date Faxed

REFERRING PHYSICIAN

Name
Address City/ST Zip
Phone ( )
Office Contact

To Be Completed by Physician

☐ **Initial Consult** ☐ **Procedure**

Requested MD	**Please circle choice**		
Stuart Sherman	Glen Lehman	Evan Fogel	First Available
Lee McHenry	James Watkins	Gregory Coté	

Patient is a Candidate for : Moderate Sedation General Anesthesia

Patient on Anticoagulant: Yes No

Diagnosis _____

Patient History and Reason for Referral:

Signature of Ordering Physician_____ **Date**_____

Scheduling Preference First Available M T W Th F AM or PM

Please send/fax completed form with medical records, recent CT/MRI reports, history and physical, recent labs, front and back of insurance card to: FAX: (317) 278-3178.

Address: Select Physician, IU Medical Center, 550 N. University Blvd., UH 4100, Indianapolis, IN 46202
ERCP website: http://medicine.iupui.edu/ercp