



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 (handcarry to appointment), history and physical, recent labs, front and back of insurance card to: FAX: (317) 968-1066.