Indiana University Health

ERCP Referral

Consult and/or Procedure
Fax To: (317) 968-1066
Phone: (317) 944-0980
http://medicine.iupui.edu/ercp

PATIENT INFORMATION

Name: _____ **Date of birth:** _____ **IU MRN:** _____

Cell phone: _____ **Home phone:** _____ **Email:** _____

Social Security #: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Patient on Anticoagulant: ☐ **YES** ☐ **NO** **Patient Weight:** _____ **Patient Height:** _____

MRI Contraindicated: ❒ YES ❒ NO **X-Ray Dye Allergy:** ❒ YES ❒ NO **Latex Allergy:** ❒ YES ❒ NO

REQUESTED PHYSICIAN:

☐ First Available ☐ Mark Gromski ☐ Aditya Gutta ☐ Ite Obaitan

☐ Evan Fogel ☐ Jeffrey Easler ☐ James Watkins ☐ Nasir Saleem

REFERRING PHYSICIAN NAME: _____

Office Address: _____ **City:** _____

State: _____ **Zip:** _____ **Phone:** _____ **Fax:** _____

Office Contact Name and #: _____

REQUIRED CLINICAL INFORMATION: *Missing information will result in scheduling delay.*

- ❒ **Reports of any abdominal imaging (CT, MRI)**
- ❒ **Push abdominal imaging to IU Cloud OR mail CD of imaging to address below**
- ❒ **Recent office visit notes**
- ❒ **Front & back of insurance card**
- ❒ **Previous procedures**
- ❒ **Relevant labs**

DIAGNOSIS/REASON FOR REFERRAL: _____ **ICD 10 CODE:** _____

REQUESTED PROCEDURE(S): _____

Complete section below only if unable to include a copy of front and back of patient's insurance card.

INSURANCE NAME/PLAN: _____ **NETWORK AFFILIATION:** _____

SUBSCRIBER NAME: _____ **ID#:** _____

GROUP #: _____ **EFFECTIVE DATE:** _____ **SUBSCRIBER DOB:** _____

HMO: ❒ **YES** ❒ **NO** **IF YES, PRIMARY CARE MD:** _____

SECONDARY INSURANCE: _____

For IU Health's most commonly accepted insurance, go to: https://iuhealth.org/pay-a-bill/most-commonly-accepted-insurances