University of Chicago Medicine
Referral for CERT Procedure

THE UNIVERSITY OF CHICAGO MEDICINE

Patient Name: _____
MR#: _____

(773) 702-1459 phone / 7:30 a.m.- 5 p.m.
(773) 834-8891 fax

Office Use Only:

Date of Procedure: _____

Time: _____

Date of Referral: _____/_____/_____

Refer Patient To (circle):

Irving Waxman, MD Uzma Siddiqui, MD Andres Gelrud, MD

.

Procedure To Be Performed (check all that apply):

□ EGD (Upper GI Endoscopy) □ Dilatation □Enteral Stent □ Colonoscopy with EMR

□ Flexible Sigmoidoscopy with EMR

□ERCP
- □ Sphinterotomy
- □ Stent
- □ Brushings
- □ Other

□ EUS
- □ Pancreas/Biliary
- □ Upper GI Tract
- □ Rectum
- □ Other

□ Celiac Plexus Neurolysis (CPN)

(ICD-9 code must be included)** _____ _____ _____ **(ICD9 codes attached)**

Clinical Indication/Reason for Procedure (required): Be specific with clinical history and why the procedure is being requested)

_____
_____
_____
_____

Please indicate the date and type of last endoscopic procedure: _____

Please send all outside records including:

□ Patient demographics and Insurance Information
□ Prior Endoscopy Report(s)
□ Prior Pathology Report(s)
□ Imaging studies (CT, MRI, MRCP, Barium Studies)
□ History and Physical
□ Bloodwork
□ Cardiac Records

Please Print and Sign
Requesting Physician Signature (required): _____
Requesting Physician Name (required): _____

Office Phone (required):_____ Office Fax (required):_____

Office Address: _____

_____

Procedure will not be scheduled unless entire form is completed and signed.