

Obstetrics and Gynecology Referral

PHONE: 304-598-4880 / FAX: 304-285-7378 / 6040 University Town Centre Drive, Morgantown, WV 26501 Date of Referral: ____/___ Referring Physician: Contact Person: Fax #: Address: _____ Reason for Referral: PATIENT INFORMATION Name: (Last) (First) (MI) Social Security #: _____ DOB: ____/____ Address: Home #: ______ Work #: _____ INSURANCE INFORMATION Insurance Co. Name: Policy ID #: Subscriber's Name: _____ **REQUESTED SERVICES** ☐ Request for consultation & opinion ☐ Request for provider to assume care ☐ Request for provider to perform procedure **PATIENT DOCUMENTS** ☐ WVHIN ☐ EPIC If not, FAX or MAIL the following: ☐ Patient records ☐ Diagnosis, condition, signs, and symptoms ☐ Copy of insurance/Rx card