Pediatric Plastic Surgery Referral

PHONE: **304-293-1346** FAX: **304-293-2556** **PO Box 9238, Morgantown, WV 26506-9238**

Date of Referral: ______/______/______

Referring Physician: ______________________________ Contact Person: ______________________________

Phone #: ______________________________ Fax #: ______________________________

Address: ____

Reason for Referral: ____

PATIENT INFORMATION

Name: (Last) ______________________________ (First) ______________________________ (MI) ______

DOB: ______/______/______ Social Security #: ______________________________

Address: ____

Home #: ____________________ Cell #: ____________________ Work #: ____________________

INSURANCE INFORMATION

Insurance Co. Name: ____

Policy ID #: ______________________________ Subscriber's Name: ______________________________

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Current medication list**
- ☐ **History and physical**
- ☐ **Office notes**
- ☐ **Operative reports**
- ☐ **Pathology reports**
- ☐ **Copy of insurance/Rx card**
- ☐ **Imaging reports and images on CD**

Important specialty specific notes:
(If the Image Grid is unavailable, please have patient hand-carry image CD or mail to:

Department of Surgery
PO Box 9238
64 Medical Center Drive
Morgantown, WV 26506-9238