WVU Medicine Children's

Genetics Referral

PHONE: **304-293-7332** FAX: **304-974-3257** **PO Box 9214**
Morgantown, WV 26506-9214

Date of Referral: _____/_____/_____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____
Reason MUST be filled in: do not use "see attached" or "genetic testing."

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

CLINIC PREFERENCE

- ☐ **Martinsburg**
- ☐ **Morgantown**
- ☐ **Princeton**
- ☐ **Scott Depot**
- ☐ **Summersville**
- ☐ **Vienna**
- ☐ **Wheeling**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Pertinent labs and reports**
- ☐ **Copy of insurance/Rx card**