WVU Medicine Children's

Pediatric Cholesterol Clinic Referral

PHONE: **304-598-4835** FAX: **304-598-6061** **PO Box 9214**
Morgantown, WV 26506-9214

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 #: _____

Parent/Guardian Name: _____ DOB: _____/_____/_____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

Guarantor Name: _____ DOB: _____/_____/_____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Office notes**
- ☐ **Lipid panel**
- ☐ **ALT and AST**
- ☐ **Copy of insurance/Rx card**

Once we have received the required information, we will contact your office with an appointment date and time.

Important specialty specific notes:

_____ Glucose (fasting

_____ Insulin serum

Department of Pediatrics
PO Box 9214
Morgantown, WV 26506-9214