

PHONE: **681-867-0362** / FAX: **304-418-1093** / **1325 Locust Ave Fairmont, WV, 26354**

Date of Referral: ____/____/____ Fairmont Medical Center Cancer Clinic Date: ____/____/____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

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☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ Demographics (face-sheet), including insurance information
- ☐ Office notes, including most recent with the reason for referral and hospital discharge notes
- ☐ Chemotherapy/radiation/treatment records
- ☐ Operative reports, if applicable
- ☐ Recent laboratory tests
- ☐ Diagnostic and staging radiology reports
- ☐ Diagnostic pathology reports, including markers, if applicable

Mail radiology CDs or scans to:

Nurse Navigator, Fairmont Medial Center
Cancer Clinic
1325 Locust Ave
Fairmont, WV, 26354

Mail all pathology slides to:

Pathology / Trans, WVU Medicine
1 Medical Center Drive
Hospital PO BOX 9203
Morgantown, WV 26506-9203

PATHOLOGY

Please have diagnostic pathology slides requested and sent to the listed address.

Slides requested on: ____/____/____ From: _____

IMAGING

Please have all relevant imaging pushed to Image Grid, if available. If not, please overnight.

To Image Grid: _____ Overnighted: _____