

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: \_\_\_\_\_