

Gastroenterology/Hepatology Clinic Consult

PHONE: **304-598-4855** FAX: **304-293-4996** PO Box **9161**, Morgantown, WV **26506-8012**

Date of Referral://				
Requesting Physician:	Contact Person:			
Phone #:	Fax #:			
Address:				
Reason for Referral:				
PATIENT INFORMATION				
Name: (Last)	(First)			(MI)
DOB:/	Social Security #:		MALE	FEMALE
Address:				
Home #:	Cell #:	Work #:		
INSURANCE INFORMATION				
Insurance:	Policy ID #:			
Insurance subscriber:				
PATIENT DOCUMENTS				
□ WVHIN □ EPIC				
If documents are not located in W	VHIN or EPIC, fax or mail the following	j :		
☐ Referral letter				
☐ Last progress note				
☐ Current labs				
☐ Scan / X-ray pathology report	ts			
☐ Copy of insurance card				

IMPORTANT: Referrals over 20 pages need to be mailed (not faxed).

Use the address listed above.