WVU Medicine

Trauma Surgery Referral

PHONE: **304-598-4890** FAX: **304-293-4711** **PO Box 9238, Morgantown, WV 26506-9238**

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 #: ______________

Emergency Contact Person: ____________________ Cell #: ______________

INSURANCE INFORMATION

Insurance Co. Name: ____

Policy ID #: ____________________ Subscriber's Name: ____________________

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC** ☐ **Image Grid**

Please provide the following:

- ☐ **Current medication list**
- ☐ **History and physical**
- ☐ **Office notes**
- ☐ **Operative reports**
- ☐ **Pathology reports**
- ☐ **Copy of insurance/Rx card**
- ☐ **Imaging reports and images on CD**

If unable to electronically send or fax documents, please hand-carry to appointment or mail to:

Department of Surgery
PO Box 9238
64 Medical Center Drive
Morgantown, WV 26506-9238