WVU Medicine Children's

Pediatric Pulmonary Referral

PHONE: **304-598-4690** FAX: **304-974-3210** **PO Box 9214 Morgantown, WV 26506**

Date of Referral:______/______/______ ☐ Medically Urgent / Priority ☐ Routine

Referring Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Address: ______________________

Reason for Referral: ______________________

Type of Visit: ☐ New Problem Consultation ☐ Chronic Problem ☐ 2nd Opinion

☐ Procedure/Surgery (no consultation needed) ☐ Transfer Care from other Pulmonologist

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:______/______/______

CLINIC PREFERENCE

☐ **Martinsburg (Telemedicine)** ☐ **Parkersburg (Telemedicine)*** ☐ **Wheeling (Telemedicine)**

☐ **Morgantown (In Person)** ☐ **Summersville (Telemedicine)***

***for specific vent or airway diagnoses only**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, please fax or mail the following:

☐ **History of Current Problem**
☐ **All hospital discharge summaries**
☐ **Relevant clinic notes for one year**
(Spirometry, RAST, Total IgE, CBC, Other)

☐ **All urgent care and ED visits**
☐ **All radiographs (chest x-rays & chest CTs)**
☐ **All medication and therapies**
☐ **All laboratory reports**

Please indicate concern for:

☐ **ADD** ☐ **Autism** ☐ **Behavior/learning problem** ☐ **Developmental delay**

Interpreter required for patient or parent/guardian? ☐ ***Yes*** ☐ ***No*** ***If yes, Patient/Guardian Language:***______________