WVU Medicine

Rheumatology Referral

PHONE: **304-598-4855** FAX: **304-598-4733** **PO Box 9156, Morgantown, WV 26506**

Date of Referral: ______/______/______

Requesting Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Address: ______________________

Reason for Referral: ______________________

CLINIC PREFERENCE

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

PATIENT INFORMATION

Name: (Last) ______________________ (First) ______________________ (MI) ______

DOB: ______/______/______ Social Security #: ______________ ☐ **MALE** ☐ **FEMALE**

Address: ______________________

Home #: ______________ Cell #: ______________ Work #: ______________

INSURANCE INFORMATION

Insurance Co. Name: ______________________

Policy ID #: ______________________ Subscriber's Name: ______________________

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

☐ **Referral letter**

☐ **Last progress note**

☐ **Current labs**

☐ **Scan / X-ray pathology reports**

☐ **Copy of insurance card**