Transplant Alliance

Evaluation Consultation/Referral Request Form
Heart Transplant Program
One Medical Center Drive, Box 8301, Morgantown, WV 26506
Phone: (304) 974-3004 Fax: (304) 598-4899

Date: ____

Patient Name: ____

D.O.B: ____

Address: ____

____

Phone Number(s): ____

Name of Insurance: ____
(Please attach a copy of the front and back of the medical insurance card with this referral)

Cardiologist/Referring Provider Name: ______________________________

Office Phone Number: ______________________________

Reason for Heart Failure: ______________________________

Please fax this referral form and a copy of the patient's medical records, including most recent H&P, discharge summary, laboratory results, chest x-ray, EKG, cardiac studies, right heart catheterization/ left heart catheterization results, echocardiogram report, recent pap smear, mammogram, and immunization records to WVU Medicine Transplant Alliance at (304) 598-4899. Once the patient is scheduled for an evaluation appointment, a confirmation letter will be sent to the patient, cardiologist, and referring provider. Thank you.