WVU Cancer Institute

Hem Onc Referral

FAX: **304-598-4553** / SECURE EMAIL: **mbrccreferralcoordinator@wvumedicine.org** / **WVUMedicine.org**

PATIENT INFORMATION

Name: _____

MBRCC Appointment Date: _____/_____/_____ Date of Referral: _____/_____/_____

Diagnosis: _____

Reason for Referral: ☐ **Newly Diagnosed** / ☐ **Evaluation and Management** / ☐ **2nd Opinion** / **Other:** _____

REFERRING OFFICE INFORMATION

Physician Name: _____ Office Fax #: _____

Contact Name: _____ Office Phone #: _____

REQUIRED RECORD INFORMATION

Please check or indicate N/A.

- ☐ **Demographics (face-sheet), including insurance information**
- ☐ **Office notes, including most recent with the reason for referral**
- ☐ **History & Physical**
- ☐ **Operative reports, if applicable**
- ☐ **Chemotherapy / treatment records**
- ☐ **Laboratory reports, tumor markers, genetic testing results**

IMAGING

Please have all relevant imaging pushed to Image Grid if available.
If not, the patient may hand carry them.

To Image Grid: _____

Hand Carried by Patient: _____

NOTE: Diagnostic Pathology: Actual slides and blocks need to be requested and sent to the address listed here.

SLIDES REQUESTED by Referring on: _____/_____/_____ From: _____

Radiology CDs or scans, mail to:

Referral Coordinator, MBRCC
1 Medical Center Drive
PO BOX 8110
Morgantown, WV 26506-8110

PHONE: **304-598-4500**

All Pathology slides, mail to:

Pathology / Trans, WVU Medicine
1 Medical Center Drive
PO BOX 9203
Morgantown, WV 26506-9203