WVUMedicine

Center for Reproductive Medicine Referral

PHONE: **304-598-3100** FAX: **304-598-8301** **PO Box 9186, Morgantown, WV 26506-9186**

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 #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

REQUESTED SERVICES

- ☐ **Request for consultation & opinion**
- ☐ **Request for provider to assume care**
- ☐ **Request for provider to perform procedure**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Patient records**
- ☐ **Diagnosis, condition, signs, and symptoms**
- ☐ **Copy of insurance/Rx card**