WVU Medicine

High-Risk Obstetrics and Genetics Referral

PHONE: **304-598-4878** FAX: **304-598-6245** **PO Box 782 Morgantown, WV 26507-0782**

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: _____

CLINIC PREFERENCE

☐ **Morgantown** ☐ **Beckley** ☐ **Martinsburg**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Prenatal records**
- ☐ **Lab reports**
- ☐ **Ultrasound reports (including first ultrasound**
- ☐ **Staff notes**
- ☐ **Copy of insurance/Rx card**

If the patient has seen another specialist for the condition for which she is being referred, please obtain the relevant records and forward for our review.