WVU Medicine Children's

Pediatric Psychiatry Referral

PHONE: 304-293-5323 FAX: 304-293-9634 930 Chestnut Ridge Road
Morgantown, WV 26505-2854

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 #: _____

Parent/Guardian Name: _____ DOB: _____/_____/_____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

Guarantor Name: _____ DOB: _____/_____/_____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

☐ **Copy of insurance/Rx card**

Please indicate if request is:

☐ **Urgent** ☐ **Non-urgent**

If urgent, please provide reason:

_____

_____

_____

If patient is at risk for self-harm, harm to others, or in acute psychiatric episode, please call the MARS line at 304-598-6100 to page the staff on-call.

REQUESTED SERVICES

☐ **Referral to Behavioral Medicine for evaluation and follow-up**

☐ **Referral to Behavioral Medicine for evaluation and recommendations**

☐ **Questions regarding patient management (appropriate therapy and/or medication)**

☐ **Referral to Pediatric Group Practice for evaluation and recommendations**

☐ **Neuropsychological testing**

☐ **Psychotherapy evaluation and treatment**