

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: ____/____/____

CLINIC PREFERENCE

- | | | | | |
|-------------------------------------|-------------------------------------|--------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Morgantown | <input type="checkbox"/> Charleston | <input type="checkbox"/> Lewisburg | <input type="checkbox"/> Parkersburg | <input type="checkbox"/> Triadelphia |
| <input type="checkbox"/> Beckley | <input type="checkbox"/> Glenville | <input type="checkbox"/> Martinsburg | <input type="checkbox"/> Summersville | |

PATIENT DOCUMENTS

- WHIN EPIC

If not, FAX or MAIL the following:

- | | |
|--|--|
| <input type="checkbox"/> Patient records | <input type="checkbox"/> Telemetry tracings |
| <input type="checkbox"/> Office notes | <input type="checkbox"/> CXR report |
| <input type="checkbox"/> Lipid lab results | <input type="checkbox"/> Copy of insurance/Rx card |
| <input type="checkbox"/> EKG tracing | |
| <input type="checkbox"/> Echo results | |

Important specialty specific notes:
(If the Image Grid is unavailable, please have patient hand-carry image CD or mail to:

Department of Pediatrics
PO Box 9214
Morgantown, WV 26506-9214