WVU Medicine

Neurology Referral

PHONE: **304-598-6127** FAX: **304-598-6442** **PO Box 9180, Morgantown, WV 26506-9180**

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: _____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Diagnosis and symptoms**
- ☐ **Radiographic studies completed with date**
- ☐ **Radiology reports and/or lab results**
- ☐ **Recent progress notes and any other pertinent information related to diagnonsis**
- ☐ **Copy of insurance/Rx card**

Has this patient been seen by a neurologist for the same or similar problem before?

☐ **YES** ☐ **NO**

Please have patient hand carry pertinent radiographic studies on CD.