WVU Medicine

# Otolaryngology Head & Neck Surgery Referral

PHONE: **855-WVU-CARE** FAX: **304-598-6899** **PO Box 782, Morgantown, WV 26506-0782**

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: _____

## PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

**If not, FAX or MAIL the following:**

- ☐ **History and physical**
- ☐ **Office notes**
- ☐ **Pathology reports/slides**
- ☐ **Surgical reports**
- ☐ **Chemotherapy/radiation reports**
- ☐ **Copy of insurance/Rx card**
- ☐ **Imaging reports and images on CD**

**Important specialty specific notes:**
(If the images are uploaded to Image Grid, you do not need to send a CD.)

Mail imaging CD to:

**Head and Neck Nurse Coordinator**
**WVU Medicine Otolaryngology**
**PO BOX 782**
**1 Medical Center Drive**
**Morgantown, WV 26506-0782**