

Date of Referral: ____/____/____

Requesting Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: ____/____/____ Social Security #: _____ **MALE** **FEMALE**

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance: _____ Policy ID #: _____

Insurance subscriber: _____

PATIENT DOCUMENTS **WVHIN** **EPIC**

If documents are not located in WVHIN or EPIC, fax or mail the following:

 Referral letter **Last progress note** **Current labs** **Scan / X-ray pathology reports** **Copy of insurance card****IMPORTANT: Referrals over 20 pages need to be mailed (not faxed).**

Use the address listed above.