WVUMedicine

Genetics Referral

PHONE: **304-293-7332** FAX: **304-293-4337** **PO Box 9214, Morgantown, WV 26506-9214**

Date of Referral: ______/______/______

Referring Physician: ____________________ Contact Person: ____________________

Phone #: ____________________ Fax #: ____________________

Address: ____

Reason for Referral: ____

Reason MUST be filled in: do not use "see attached" or "genetic testing."

PATIENT INFORMATION

Name: (Last) ____________________ (First) ____________________ (MI) ______

DOB: ______/______/______ Social Security #: ____________________

Address: ____

Home #: ______________ Cell #: ______________ Work #: ______________

INSURANCE INFORMATION

Insurance Co. Name: ____

Policy ID #: ____________________ Subscriber's Name: ____________________

CLINIC PREFERENCE

- ☐ **Beckley (In Person)**
- ☐ **Charleston (In Person)**
- ☐ **Huntington (In Person)**
- ☐ **Morgantown (In Person)**
- ☐ **Martinsburg (In Person)**
- ☐ **Parkersburg (In Person)**
- ☐ **Summersville (In Person)**
- ☐ **Wheeling (In Person)**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Pertinent labs and reports**
- ☐ **Copy of insurance/Rx card**