WVU Medicine Children's

Pediatric Endocrinology Referral

PHONE: **304-293-1201** FAX: **304-974-3250** **PO Box 9214 Morgantown, WV 26506**

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

☐ **Martinsburg (Telemedicine)** ☐ **Morgantown (In Person)** ☐ **Summersville (In Person)**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

☐ **Office notes**
☐ **Growth charts and lab results**
☐ **Radiology reports and images on CD**
☐ **Copy of insurance/Rx card**
☐ **Copy of pharmacy benefit card (if available)**

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

Review may take up to 1 week and will begin only after ALL records are provided.