WVU Medicine Children's

Pediatric Neurology Referral

PHONE: **304-598-4835** FAX: **304-598-6061** **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

- ☐ **Morgantown (In Person)**
- ☐ **Elkins (In Person)**
- ☐ **Lewisburg (In Person)**
- ☐ **Summersville (In Person)**
- ☐ **Wheeling (In Person)**
- ☐ **Martinsburg (Telemedicine)**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, have patient hand-carry the following:

- ☐ **Prior/pending Neuro evaluation with location and consultation reports (if any)**
- ☐ **Growth charts and lab results**
- ☐ **EEG and EMG**
- ☐ **Pathology/biopsy reports**
- ☐ **Radiology reports and images on CD**
- ☐ **Copy of insurance/Rx card**

Please indicate concern for:

☐ **ADD** ☐ **Autism** ☐ **Behavior/learning problem** ☐ **Developmental delay**