WVU Medicine Children's

Pediatric Neurosurgery Clinic Referral

PHONE: **304-598-6127** / FAX: **304-598-4047** / **PO Box 9214 Morgantown, WV 26506**

Date of Referral:______/______/______

Referring Physician: ____

Phone #: ______________________ Fax #: ______________________

Address: ____

Contact Person: ____

ALL new patient referrals are required to fax this form PRIOR to appointment being made.
Please include **ALL** medical history, demographics, insurance information & any testing reports to the Pediatric Neurosurgery Department. Some appointments may require additional review by the provider prior to scheduling.
Please fax all requested documents to FAX #: 304-598-4047. Please fill out in its entirety!

PATIENT INFORMATION

Name: (Last)______________________(First)______________________(MI) _______

DOB:_______/_______/_______Social Security #:__________________WVU Medical Record #: __________________

Address: ____

Home #:__________________Cell #:__________________Work #: __________________

PATIENT INSURANCE INFORMATION

Insurance Co. Name:______________________________ **HMO** or **PPO** (Please circle.)

Policy ID #:______________________ Group #: ______________________

Subscriber's Name:__________________DOB:_______/_______/_______SS#: __________________

Please attach a copy of the patient's card.

CLINIC PREFERENCE

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

MEDICAL INFORMATION

Diagnosis/Symptoms: ____

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Relevant radiographic studies and findings: ____

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Fax all pertinent records with referral. Original radiographic films MUST accompany patient at time of visit (preferably on a CD).

Office use only: **Clinic Appointment Date: ☐ M ☐ T ☐ W ☐ Th ☐ F**_______/_______/_______ **Time:**__________ ☐ **AM** / ☐ **PM**

Mark R. Lee, MD, PhD, MBA / **Hal Meltzer,** MD / **Cesar A. Serrano,** MD, FRCSC, FAANS