WVU Medicine

Pulmonary/Sleep Referral

PHONE: **304-598-4855** FAX: **304-598-6880** **Physician Office Center, 3rd floor Medical Specialties Suite**

This form is not to be used for scheduling purposes.

Dear Provider:

Thank you for referring your patient to our Pulmonary Clinic. To better evaluate your patient during his or her intial visit, we are requesting that you complete and fax this form back to us along with copies of records and information listed below.

Scheduled appointment: _____/_____/_____ at _____ **AM** **PM**

CLINIC PREFERENCE

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

PATIENT INFORMATION

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

DOB: _____/_____/_____ Social Security #: _____

Address: _____

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

PATIENT INSURANCE INFORMATION

Insurance Co. Name: _____

Please attach a copy of the patient's card.
Fax to 304-598-6859, ATTN: Sherri Trickett.

Date of Referral: _____/_____/_____

Provider/Clinic name: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for referral: _____

Please fax the following information along with this form to our office within 3 business days.

1. Patient medication list
2. Last three office notes
3. Lab test results
4. CXR / CT scan results
5. Any other procedure results
6. Any pertinent records

Instruct patient to bring copy of CXR / CT scan on a CD.

The appointment may need to be rescheduled if the requested records and information are incomplete.