WVU Medicine Children's

Pediatric Neurology Referral

PHONE: **304-598-4835** FAX: **304-974-3247** **PO Box 9214**
Morgantown, WV 26506-9214

Date of Referral: _____/_____/_____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

What is the question that needs answered? _____

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** ☐ **Elkins** ☐ **Lewisburg** ☐ **Martinsburg-***Telemedicine*

☐ **Summersville** ☐ **Wheeling** ☐ **Vienna MOV-***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**