

Hepato-Pancreato-Biliary Surgery Referral

PHONE: **304-598-4890** / FAX: **304-293-4824** / PO Box **9238**, Morgantown, WV **26506-9238** Date of Referral: _____/____ Referring Physician: Contact Person: Phone #: Fax #: Address: _____ Reason for Referral: PATIENT INFORMATION DOB: ____/____ Social Security #: _____ Address: _____ Home #: ______ Work #: _____ **INSURANCE INFORMATION** Insurance Co. Name: _____ Policy ID #: _____ Subscriber's Name: _____ PATIENT DOCUMENTS ☐ WVHIN ☐ EPIC If not, FAX or MAIL the following: ☐ Current medication list Important specialty specific notes: (If the Image Grid is unavailable, please have patient ☐ History and physical hand-carry image CD or mail to: ☐ Office notes **Department of Surgery** ☐ Operative reports PO Box 9238 ☐ Pathology reports **64 Medical Center Drive** Morgantown, WV 26506-9238 ☐ Copy of insurance/Rx card ☐ Imaging reports and images on CD