WVU Medicine

Maternal-Fetal Medicine and Genetics Referral

PHONE: **304-598-4878** FAX: **304-598-6245** **PO Box 782, Morgantown, WV 26507-782**

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 #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

REQUESTED SERVICES

- ☐ **MFM consultation and treatment**
- ☐ **Transfer of care**
- ☐ **Ultrasound only (with permission to consult if unexpected issue arises)**
- ☐ **Genetic consultation only**
- ☐ **Genetic consultation and ultrasound**
- ☐ **Genetic consultation, MFM consultation, and treatment**
- ☐ **Mental health counseling**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Prenatal flow sheets**
- ☐ **Labs and ultrasounds**
- ☐ **Staff notes**
- ☐ **Copy of insurance/Rx card**

PLEASE COMPLETE:

Gravida/Para: _____

LMP: _____/_____/_____ = EDD: _____/_____/_____

Patient's age at EDD: _____

Ultrasound Date: _____/_____/_____

= _____ Weeks _____ Days = EDD: _____/_____/_____