

**UHC Cardiology**  
527 Medical Park Drive  
Suite 106  
Bridgeport, WV 26330  
Phone: 681.342.3840  
Fax: 681.342.3845

## REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX to: 681.342.3845

Referring Provider: \_\_\_\_\_ Referring Office Name: \_\_\_\_\_

Referring Provider Phone #: \_\_\_\_\_ Office FAX #: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Patient's SSN: \_\_\_\_\_

Patient's Name (F,MI,L): \_\_\_\_\_ Patient's Address: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_ Patient's Phone #: \_\_\_\_\_

Patient's Insurance/ Auth #'s: \_\_\_\_\_

Reason for Referral (please be specific): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### **Please Note:**

- The following information **MUST** accompany this referral: Most recent catheterization report, echocardiogram report, EKG.
- Please have the patient bring films or CDs if test results are not accessible through EPIC.
- Please include office notes, surgery reports, and any additional information pertinent to this referral.
- Please send Insurance Authorization information as required by the patient's insurance, along with this referral.
- We will notify the patient of appointment time and date.

**Thank you for your referral.**  
**Please do not hesitate to call us with any questions or concerns.**