WVU Medicine
UNITED HOSPITAL CENTER

GENERAL SURGERY
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Appointment Referral Form

GENERAL SURGERY

***Please complete form, fax to 681-342-3894, and advise your patient that our office will be calling them with appointment date and time**

Referral Date:_____ **Referring Provider:**_____

Staff Name:_____ **Office Phone:** _____

Fax Number:_____ **Location:** _____

Patient's Name:_____ **DOB:**_____

Address:_____

Home #:_____ **Cell#:**_____ **SS#:**_____

Primary and Secondary Ins:_____ **M or F**

***Can the patient make their own medical decisions and sign medical consents? Yes No**
(If NO, a legal representative, guardian or medical power of attorney MUST accompany the patient and provide all legal documents)
***Does this patient's insurance require an authorization to see a specialist? Yes No**
Authorization Information:_____

COLONOSCOPY REFERRALS (CIRCLE ONE) : Screening High Risk Diagnostic

- **Chief Complaint / Reason for referral:**_____
- **Work Up that determined a surgical consult; when and where:**
- **Labs:**_____
- **Pathology:**_____**Office Notes:**_____
- **ER Visits:**_____
- **Diagnostics:**_____
- **Requested NON-UHC records:** _____
- **Other:**_____
- **Please send all essential records the surgeon may need to determine surgery.**

Preferred: Dr. Madden Dr. Costa Dr. Vasani Dr. Raymond Dr. Miller 1st Available

Other notes/requests regarding appointment:_____
Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only: Acct #_____ **Appt. Date & Time:**_____