WVUMedicine

UNITED HOSPITAL CENTER

UHC Pulmonology and Sleep Medicine
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REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-4501

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 PET Scan, CT Scan, X-Rays and Pathology Reports.

❒ Please have the Patient bring films or CD's if these exams are not accessible through UHC's PAC System.

❒ Please include office notes, surgery reports, 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 by mail or phone of appointment time and date.

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

Office Use Only
Provider:
EPIC MRN:
Appointment Date:
Appointment Time: