WVU Medicine
UNITED HOSPITAL CENTER

UHC GASTROENTEROLOGY

527 Medical Park Drive
Suite 402
Bridgeport, WV 26330
Phone / 681.342.3690
Fax / 681.342.3695

Appointment Referral Form

GASTROENTEROLOGY

***Please complete form, fax to 681-342-3695 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 medial power of attorney MUST accompany the patient and provide all legal documents)

*Does the patient's insurance require an authorization to see a specialist? Yes No

Reason for referral: _____

Physician Preference: _____ or 1st Available: _____

Please Note:

- **Please include most recent progress notes, lab results, pathology reports, CT reports, and procedure reports.**
- **Please include any additional information pertinent to this referral.**
- **We will notify the patient by mail and phone of appointment time and date.**

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

Update: 12/6/24

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