

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: _____

Referral / Authorization # (if applicable): _____

PATIENT DOCUMENTS

WHIN EPIC

If not, FAX or MAIL the following:

- Current medication list
- History and physical / last progress note
- Results of any pertinent testing (cardiac catheterizations, CTA's, ECG, stress test, echocardiogram, vascular studies, vascular ultrasounds, arterial studies, etc.)
- Copy of insurance/Rx card
- Imaging reports and images on CD

Important specialty specific notes:
(If the Image Grid is unavailable, please have patient hand-carry image CD or mail to:

WVU Heart & Vascular Institute
PO Box 8500
Morgantown, WV 26506-8500

Please indicate specialty:

- Cardiac Surgery Cardiology Thoracic Surgery Vascular Surgery