WVU Medicine

Rheumatology Referral

PHONE: **304-598-4855** FAX: **304-974-3393** **PO Box 9156, Morgantown, WV 26506-9156**

Date of Referral: _____/_____/_____ EPIC: 21012130

Requesting Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

INSURANCE INFORMATION

☐ **Morgantown (In Person)** ☐ **Summersville (Telemedicine)**

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____ ☐ **MALE** ☐ **FEMALE**

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Referral letter**
- ☐ **Last progress note**
- ☐ **Current labs**
- ☐ **Scan / X-ray pathology reports**
- ☐ **Copy of insurance card**