WVU Medicine

Occupational Medicine Referral

PHONE: **304-293-3693** FAX: **304-293-2629** **PO Box 9145, Morgantown, WV 26506-9145**

Date of Referral: ______/______/______

Referring Physician: ______________________ Contact Person: ______________________

Phone #: ______________________ Fax #: ______________________

Address: ____

Reason for referral and/or symptoms: ____

____ Dx code: ______________

REQUESTED SERVICES

- ☐ **Request for consultation (We do NOT assume care.)**
- ☐ **Request for referral (We assume care for specified condition.)**

Please send ALL medical records.

PATIENT INFORMATION

Name: (Last) ______________________ (First) ______________________ (MI) ______

DOB: ______/______/______ Social Security #: ______________________

Address: ____

Home #: ______________ Cell #: ______________ Work #: ______________

INSURANCE INFORMATION

Insurance Co. Name: ______________________ Policy ID #: ______________________

Subscriber's Name: ______________________ Authorization #: ______________________

WORKERS COMPENSATION INFORMATION

Workers Compensation Carrier: ______________________ Date of injury: ______/______/______

Address: ____

Claim #: ______________________ Authorization #: ______________________

Claims Manager: ______________________ Phone #: ______________________

Employer: ______________________ Phone #: ______________________