

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: _____

PATIENT DOCUMENTS

WHIN EPIC

If not, FAX or MAIL the following:

- Current medication list
- History and physical
- Office notes
- Operative reports
- Pathology reports
- 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:

**Department of Otolaryngology
PO Box 782
1 Medical Center Drive
Morgantown, WV 26506**