



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 #: _____

Parent/Guardian Name: _____ DOB: ____/____/____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

Guarantor Name: _____ DOB: ____/____/____

CLINIC PREFERENCE

- Morgantown Charleston Martinsburg Summersville Wheeling
- Beckley Huntington Princeton Vienna

PATIENT DOCUMENTS

- WHIN EPIC

If not, FAX or MAIL the following:

- Patient records Telemetry tracings
- Office notes CXR report
- Lipid lab results Copy of insurance/Rx card
- EKG tracing
- Echo results

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

Department of Pediatrics
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Morgantown, WV 26506-9214