Pediatric Cardiology Referral

WVU Medicine Children's

PHONE: 304-598-4835 FAX: 304-293-1409 PO Box 9214
Morgantown, WV 26506-9214

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** ☐ **Lewisburg** ☐ **Princeton** ☐ **Triadelphia**

☐ **Beckley** ☐ **Glenville** ☐ **Martinsburg** ☐ **Summersville** ☐ **Vienna**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

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

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

Department of Pediatrics
PO Box 9214
Morgantown, WV 26506-9214