Pediatric Neurology Referral

WVUMedicine**Golisano**Children's
NEUROSCIENCE CENTER
Operated by WVU Hospitals

PHONE: **304-598-4835**   FAX: **304-974-3247**   **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

☐ **Elkins** - *Telemedicine*   ☐ **Martinsburg** - *Telemedicine*   ☐ **Princeton**   ☐ **Wheeling**

☐ **Gilbert**   ☐ **Morgantown**   ☐ **Summersville**

☐ **Lewisburg** - *Telemedicine*   ☐ **Moundsville**   ☐ **Vienna**

PATIENT DOCUMENTS

☐ **WVHIN**   ☐ **EPIC**

If not, have patient hand-carry the following:

☐ **Prior/pending Neuro evaluation with location and consultation reports (if any)**   ☐ **Growth charts and lab results**   ☐ **Radiology reports and images on CD**

☐ **EEG and EMG**   ☐ **Copy of insurance/Rx card**

☐ **Pathology/biopsy reports**

Please indicate concern for:

☐ **ADD**   ☐ **Autism**   ☐ **Behavior/learning problem**   ☐ **Developmental delay**