Pediatric Neurology Referral

WVU Medicine Children's

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*
- ☐ **Gilbert**
- ☐ **Lewisburg** - *Telemedicine*
- ☐ **Martinsburg** - *Telemedicine*
- ☐ **Morgantown**
- ☐ **Moundsville**
- ☐ **Princeton**
- ☐ **Summersville**
- ☐ **Vienna**
- ☐ **Wheeling**

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**
- ☐ **EEG and EMG**
- ☐ **Pathology/biopsy reports**
- ☐ **Radiology reports and images on CD**
- ☐ **Copy of insurance/Rx card**

Please indicate concern for:

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