WVU Medicine Children's

Pediatric Pulmonary Referral

PHONE: 304-598-4835 FAX: 304-974-3210 PO Box 9214
Morgantown, WV 26506

Date of Referral: ____/____/____ ☐ Medically Urgent / Priority ☐ Routine

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

Type of Visit: ☐ New Problem Consultation ☐ Chronic Problem ☐ 2nd Opinion

☐ Procedure/Surgery (no consultation needed) ☐ Transfer Care from other Pulmonologist

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

☐ **Martinsburg** ☐ **Princeton** ☐ **Vienna**

☐ **Morgantown** ☐ **Summersville** ☐ **Wheeling**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, please fax or mail the following:

☐ **History of current problem**
☐ **All hospital discharge summaries**
☐ **Relevant clinic notes for one year**
(Spirometry, RAST, Total IgE, CBC, Other)
☐ **All urgent care and ED visits**
☐ **All radiographs (chest x-rays & chest CTs)**
☐ **All medication and therapies**
☐ **All laboratory reports**

Please indicate concern for:

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

Interpreter required for patient or parent/guardian? ☐ ***Yes*** ☐ ***No*** ***If yes, Patient/Guardian Language:*** _____