WVU Medicine Children's
NEUROSCIENCE CENTER
PHONE: 304-598-6127 FAX: 304-598-4047 1 Medical Center Drive, PO Box 9183
Morgantown, WV 26506

Pediatric Neurosurgery Clinic Referral

Date of Referral: _____/_____/_____

Referring Physician: _____

Phone #: _____ Fax #: _____

Address: _____

Contact Person: _____

ALL new patient referrals are required to fax this form PRIOR to appointment being made.
Please include **ALL** medical history, demographics, insurance information & any testing reports to the Pediatric Neurosurgery Department. Some appointments may require additional review by the provider prior to scheduling.
Please fax all requested documents to FAX #: 304-598-4047. Please fill out in its entirety!

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____ WVU Medical Record #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

PATIENT INSURANCE INFORMATION

Insurance Co. Name: _____ **HMO** or **PPO** (Please circle.)

Policy ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: _____/_____/_____ SS #: _____

Please attach a copy of the patient's card.

CLINIC PREFERENCE

☐ **Martinsburg** ☐ **Morgantown** ☐ **Princeton** ☐ **Vienna** ☐ **Wheeling**

MEDICAL INFORMATION

Diagnosis/Symptoms: _____

_____

Relevant radiographic studies and findings: _____

_____

Fax all pertinent records with referral. Original radiographic films MUST accompany patient at time of visit (preferably on a CD).

Office use only: **Clinic Appointment Date: M T W Th F** _____/_____/_____ **Time:** _____ **AM / PM**

P. David Adelson, MD, FACS, FAAP **Kimberly Hamilton**, MD **Hal S. Meltzer**, MD, FAANS