WVU Medicine

Pediatric Surgery Referral

PHONE: **304-598-4890** FAX: **304-293-6459** **PO Box 9238, Morgantown, WV 26506-9238**

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 #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Current medication list**
- ☐ **History and physical**
- ☐ **Office notes**
- ☐ **Operative reports**
- ☐ **Pathology reports**
- ☐ **Copy of insurance/Rx card**
- ☐ **Imaging reports and images on CD**

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

Department of Surgery
PO Box 9238
64 Medical Center Drive
Morgantown, WV 26506-9238