WVU Medicine
UNITED HOSPITAL CENTER
UHC Ophthalmology
1370 Johnson Avenue
Bridgeport, WV 26330
(681) 342-4525 Phone
(304) 848-6431 Fax

Emerson T. Que, M.D.
David A. Faris, M.D.
John Nguyen, M.D.
Ghassan Ghorayeb, M.D.
L. Carol Laxson, M.D.
Nicole Pumariega, M.D.
Kevin Halenda, M.D.

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (304) 623-5812

Referring Provider: ______________________ **Referring Office Name:** ______________________

Referring Provider Phone #: ______________________ **Office FAX #:** ______________________

Primary Care Provider: ______________________ **Today's Date:** ______________________

Person Completing Form: ______________________ **Patient's SSN:** ______________________

Patient's Name (F,MI,L): ____

Patient's Address: ____

Patient's Date of Birth: ______________________ **Patient's Phone #:** ______________________

Patient's Insurance/Auth #'s: ____

Reason for Referral (please be specific): ____

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Please Note:

❒ Please include most recent eye exams/reports.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only
Provider: ______________
EPIC MRN: ______________
Appointment Date: ______________
Appointment Time:

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