

# UNITED HOSPITAL CENTER

## UHC Orthopaedics and Sports Medicine

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Bridgeport, WV 26330

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**Other Convenient Locations:**

**UHC Orthopaedics at St. Joseph's Hospital - Buckhannon**  
**UHC Orthopaedics at Weston**  
**UHC Orthopaedics at Braxton and Summersville**

### REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-1917

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): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please Note:**

- Please include most recent progress notes, x-rays, MRI, CT reports, and procedure reports.
- Please include any additional information pertinent to this referral.
- We will notify the patient by mail or phone of appointment time and date.

**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:	_____