WVUMedicine
UNITED HOSPITAL CENTER

UHC Internal Medicine
527 Medical Park Drive
Suite 307
Bridgeport, WV 26330
Phone: 681.342.3850
Fax: 304.933.3319

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX to: 304.933.3319

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:

□ The following information MUST accompany this referral: Most recent progress notes, labs, x-rays, MRI, EKG and CT reports.

□ Please have the patient bring films or CDs if test results are not accessible through EPIC.

□ Please include office notes, surgery reports, and any additional information pertinent to this referral.

□ Please send Insurance Authorization information as required by the patient's insurance, along with this referral.

□ We will notify the patient of appointment time and date.

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