WVUMedicine
UNITED HOSPITAL CENTER

UHC Plastic & Reconstructive Surgery
527 Medical Park Drive
Suite 203
Bridgeport, WV 26330
Phone: 681.342.3190
Fax: 681.342.3195

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX to: 681.342.3195

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:

□ 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.