

# UNITED HOSPITAL CENTER

**UHC Neurosurgery, Spine, & Pain Center**  
227 Medical Park Drive, Suite 103  
Bridgeport, WV 26330

681.342.3508 Phone  
681.342.1918 FAX

Other Convenient Locations:  
UHC Pain Clinic at St. Joseph's Hospital - Buckhannon  
UHC Pain Clinic at Weston

**Physiatry**  
Russell Biundo,MD  
Gary Barcinas,PA  
Jon Adams,FNP  
1st Available

**PLEASE CIRCLE DESIRED PROVIDER**

**Neurosurgery**  
Bill Underwood,MD,PhD  
Richard Douglas,MD  
Allan Fergus,MD  
Heather Earl, PA  
Lauren Statler,FNP  
Joel Williams,FNP  
Jordan Blevins,FNP  
Bailey Filbin,PA  
1st Available  
**Pain (Interventional)**  
Nathan Berry,DO  
Annas Sabbagh,DO  
Gobind Singh,MD  
Megan Muncy,FNP  
Mary Varner,FNP  
1st Available

## REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-1918

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

### Workers Compensation

Claim # \_\_\_\_\_ Claims Adjuster: \_\_\_\_\_

Authorization # \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Approved Diagnosis Code: \_\_\_\_\_

### Please Note:

Please include most recent progress notes, x-rays, MRI, CT reports, and procedure reports.

**Must be within last 6 months**

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:	_____