WVU Medicine

Gastroenterology/Hepatology Clinic Consult

PHONE: **304-598-4855** FAX: **304-974-3393** **PO Box 9161, Morgantown, WV 26506-8012**

Date of Referral: _____/_____/_____

Requesting Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Reason for Referral: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____ ☐ **MALE** ☐ **FEMALE**

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance:_____ Policy ID #:_____

Insurance subscriber: _____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If documents are not located in WVHIN or EPIC, fax or mail the following:

- ☐ **Referral letter**
- ☐ **Last progress note**
- ☐ **Current labs**
- ☐ **Scan / X-ray pathology reports**
- ☐ **Copy of insurance card**

IMPORTANT: Referrals over 20 pages need to be mailed (not faxed).
Use the address listed above.