



Date of Referral: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: _____	Contact Person: _____
Phone #: _____	Fax #: _____
Address: _____	
Reason for Referral: _____	

**PATIENT INFORMATION**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE INFORMATION**

Insurance Co. Name: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CLINIC PREFERENCE**

- Martinsburg
- Morgantown
- Princeton
- Thomas
- Vienna
- Wheeling

**PATIENT DOCUMENTS**

- WHIN
- EPIC

**If not, FAX or MAIL the following:**

- Prior GI evaluation reports (if any) with location
- Growth charts, lab results, and stool studies
- Endoscopy and pathology/biopsy reports
- Copy of insurance/Rx card
- Radiology reports and images on CD

**Important specialty specific notes:**

(If the Image Grid is unavailable, please have patient hand-carry image CD or mail to:

**Department of Pediatrics**  
**PO Box 9214**  
**Morgantown, WV 26506-9214**

After review, the family will be contacted for scheduling. **We must speak with the family in order to schedule the visit.** Please advise families to anticipate our call within 5-7 business days. If they are unavailable when we call, we will leave a message with our contact information so they can call us back at their convenience.