

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

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

**PATIENT INFORMATION**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_    Age: \_\_\_\_    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-Telemedicine     Morgantown     Summersville

**PATIENT DOCUMENTS**

WHIN     EPIC

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

- Office notes
- Growth charts and lab results
- Radiology reports and images on CD
- Copy of insurance/Rx card
- Copy of pharmacy benefit card (if available)

**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**