

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-Telemedicine Morgantown Summersville 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.