WVU Medicine Children's

Pediatric Gastroenterology Referral

PHONE: **304-598-4835** FAX: **304-974-3201** **PO Box 9214**
Morgantown, WV 26506-9214

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** ☐ **Summersville** ☐ **Vienna MOV-telemedicine**

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **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.