WVU Medicine Children's

# Pediatric Cardiology Referral

PHONE: 304-598-4835 FAX: 304-293-1409 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

☐ Morgantown ☐ Charleston ☐ Lewisburg ☐ Parkersburg ☐ Triadelphia
☐ Beckley ☐ Glenville ☐ Martinsburg ☐ Summersville ☐ Vienna MOV-telemedicine

## PATIENT DOCUMENTS

☐ WVHIN ☐ EPIC

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

☐ Patient records
☐ Office notes
☐ Lipid lab results
☐ EKG tracing
☐ Echo results
☐ Telemetry tracings
☐ CXR report
☐ Copy of insurance/Rx card

**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**