WVU Cancer Institute

Hematopoietic Malignancy and Cellular Therapy

PHONE: **304-598-4500** FAX: **304-598-4553** **Hospital PO BOX 8110, Morgantown, WV 26506-8110**

Date of Referral: _____/_____/_____ MBRCC Appointment Date: _____/_____/_____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Reason for Referral: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____ Subscriber's Name: _____

PATIENT DOCUMENTS

☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Demographics (face-sheet), including insurance information**
- ☐ **Office notes, including most recent with the reason for referral and hospital discharge notes**
- ☐ **Chemotherapy/radiation/treatment records**
- ☐ **Operative reports, if applicable**
- ☐ **Recent laboratory tests**
- ☐ **Diagnostic and staging radiology reports**
- ☐ **Diagnostic pathology reports, including markers, if applicable**

Mail radiology CDs or scans to:

Referral Coordinator, MBRCC
1 Medical Center Drive
Hospital PO BOX 8110
Morgantown, WV 26506-8110

Mail all pathology slides to:

Pathology / Trans, WVU Medicine
1 Medical Center Drive
Hospital PO BOX 9203
Morgantown, WV 26506-9203

PATHOLOGY

Please have diagnostic pathology slides requested and sent to the listed address.

Slides requested on: _____/_____/_____ From: _____

IMAGING

Please have all relevant imaging pushed to Image Grid, if available. If not, please overnight.

To Image Grid: _____ Overnighted: _____