

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: _____