

Patient Referral Form

Bariatric Surgery
P: 304-241-1100
F: 304-983-8800

Cardiology
P: 304-329-4701
F: 304-329-4716

ENT
P: 304-329-4701
F: 304-329-4716

General Surgery
P: 304-329-4701
F: 304-329-0560

Gynecology
P: 304-329-4701
F: 304-329-0560

Neurology
P: 304-329-4701
F: 304-329-4716

Orthopedics
P: 304-329-4701
F: 304-329-4716

Podiatry
P: 304-599-9000
F: 304-599-4091

Pulmonology
P: 304-329-4701
F: 304-329-0560

Sleep Medicine
P: 304-864-2290
F: 304-864-2299

Urology
P: 304-329-4701
F: 304-329-4716

Wound Healing Center
P: 304-329-3348
F: 304-329-3867

If available, please fax the following records with this form to obtain an appointment:

- Last Provider Notes
- Laboratory Testing
- Diagnostic Images/Reports
- Current Medication and Allergy List
- PFT Results for Pulmonology Referrals

Routine Medically Urgent Pre-Op Evaluation

PATIENT INFORMATION:

First _____ MI _____ Last Name _____

DOB: _____ / _____ / _____ SS# _____ - _____ - _____

Home Phone: (____) - _____ - _____ Cellphone: (____) - _____ - _____

Address: _____

City _____ State _____ Zip _____

INSURANCE INFORMATION:

Insurance Company: _____ ID: _____ GRP: _____

Does insurance require prior authorization for specialist referral? Yes No

REFERRING PHYSICIAN INFORMATION:

Physician Name: _____

Name of person faxing information: _____

Office Fax: _____ Office Phone: _____

Reason for Visit/Symptoms: _____

Requested Physician _____ First Available _____

OFFICE USE ONLY

Patient has Appointment with:

Dr.: _____ on _____ at _____