Patient Referral Form

Mon Health
Preston Memorial Hospital

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

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

General Surgery
P: 304-329-4701
F: 304-329-4716

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

Infusion Center
P: 304-329-7280
F: 304-329-7281

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 & Vein Clinic
P: 304-329-4701
F: 304-329-4716

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_____