

# 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 \_\_\_\_\_