Patient referral form

Vandalia Health
Mon Preston Memorial Hospital

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: 304-329-4716

Medical Oncology/ Hematology
P: 304-329-7911
F: 304-329-4716

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: 304-329-4701
F: 304-329-4716

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

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

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

Vein & Wound Center
F: 304-329-4716
P: 304-329-4701

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: _____

on _____ at _____