Patient referral form

Vandalia Health
Mon Stonewall Jackson Memorial Hospital

Addiction Treatment
P: 304-884-8941
F: 304-884-8943

Cardiac Rehabilitation
P: 304-269-6004
F: 304-269-6026

General Surgery
P: 304-517-1115
F: 304-517-1119

Home Health
P: 304-269-4556
F: 866-597-0966

Home Oxygen
P: 304-269-0100
F: 304-269-4559

Obstetrics/Gynecology
P: 304-269-3108
F: 304-269-3109

Medical Oncology/ Hematology
P: 304-517-1271
F: 304-329-4716

Neurology
P: 304-269-0030
F: 304-269-0034

Orthopedics
P: 304-269-4431
F: 304-269-9803

Physical Therapy
P: 304-269-8097
F: 304-269-8187
F: 304-517-1140

Podiatry
P: 304-269-4252
F: 304-269-5443

Pulmonology
P: 304-269-0030
F: 304-269-0034

Pulmonology Rehabilitation
P: 304-269-8099
F: 304-269-8536

Sleep Lab
P: 304-269-8096
F: 304-269-8168

Urology
P: 304-269-8128
F: 304-269-8162

Vein Center
P: 304-517-1272
F: 304-517-1274

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 _____