WVU Medicine

Pediatric Neurosurgery Clinic Referral

PHONE: **304-598-6127** (Option *1) FAX: **304-598-4047** **1 Medical Center Drive, PO Box 9183 Morgantown, WV 26506**

Date of Referral:_____/_____/_____

Referring Physician: _____

Phone #: _____ Fax #: _____

Address: _____

Contact Person: _____

ALL new patient referrals are required to fax this form PRIOR to appointment being made.
Please include **ALL** medical history, demographics, insurance information & any testing reports to the Pediatric Neurosurgery Department. Some appointments may require additional review by the provider prior to scheduling.
Please fax all requested documents to FAX #: 304-598-4047. Please fill out in its entirety!

PATIENT INFORMATION

Name: (Last)_____(First)_____(MI) _____

DOB:_____/_____/_____Social Security #:_____WVU Medical Record #: _____

Address: _____

Home #:_____Cell #:_____Work #: _____

PATIENT INSURANCE INFORMATION

Insurance Co. Name:_____ **HMO** or **PPO** (Please circle.)

Policy ID #:_____ Group #: _____

Subscriber's Name:_____DOB:_____/_____/_____SS #: _____

Please attach a copy of the patient's card.

MEDICAL INFORMATION

Diagnosis/Symptoms: _____

Relevant radiographic studies and findings: _____

Fax all pertinent records with referral. Original radiographic films MUST accompany patient at time of visit (preferably on a CD).

Office use only: **Clinic Appointment Date: M T W Th F**_____/_____/_____ **Time**:_____**AM / PM**

Mark R. Lee, MD, PhD, MBA **Cesar A. Serrano,** MD, FRCSC, FAANS