Patient Referral Form

Mon Health
Preston Memorial Hospital
Vandalia Health

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

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

Hematology Oncology
P: 304-329-7911
F: 304-329-7281

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: 304-329-4716

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

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

Vein & Wound Center
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: (_____)-_____-_____ Cell Phone: (_____)-_____-_____

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:_____