



UNITED HOSPITAL CENTER

UHC Orthopaedics and Sports Medicine

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Other Convenient Locations:

UHC Orthopaedics at St. Joseph's Hospital - Buckhannon
UHC Orthopaedics at Weston
UHC Orthopaedics at Braxton and Summersville

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (681) 342-1917

Referring Provider: _____ Referring Office Name: _____

Referring Provider Phone #: _____ Office FAX #: _____

Primary Care Provider: _____ Today's Date: _____

Person Completing Form: _____ Patient's SSN: _____

Patient's Name (F,M,I,L): _____

Patient's Address: _____

Patient's Date of Birth: _____ Patient's Phone #: _____

Patient's Insurance/Auth #'s: _____

Reason for Referral (please be specific): _____

Please Note:

- Please include most recent progress notes, x-rays, MRI, CT reports, and procedure reports.
- Please include any additional information pertinent to this referral.
- We will notify the patient by mail or phone of appointment time and date.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only	
Provider:	_____
EPIC MRN:	_____
Appointment Date:	_____
Appointment Time:	_____