NEW RIVER HEALTH ASSOCIATION, INC.

Primary Care Provider **Date of Referral** ____________

☐ **New River Family Health Center**
(304) 469-2905
☐ **New River Birth Center**
(304) 469-3345
☐ **New River Breathing Center**
(304) 469-3261 Fax: (304) 465-5486

P.O. Box 337
Scarbro, WV 25917

☐ **North Fayette Family Health Center**
HC65, Box 144B
Hico, WV 25834
(304) 574-3960
Fax: (304) 574-3651

1 — PATIENT APPOINTMENT INFORMATION

Authorization # ____________

Patient ____________ Acct. # ____________ Phone ____________

Address ____________ Member ID # ____________

Specialist ____________ Phone ____________

Address ____________ Fax ____________

Appointment - Date ____________ Time ____________ Referring Provider ____________

Patient consent to report to PCP ____ Yes ____ No Patient Signature: ____________

NOTE: If it is not possible for the patient to keep this appointment, the patient is requested to phone this physician's office to set a different time.

2 — REFERRING PHYSICIAN INFORMATION

Consultant Type: Emergency ___ Urgent ___ Routine ___

Instructions: Manage ___ Managed W/PCP ___ Advise PCP ______

Specific reason for referral or test: ____________ Diagnosis Code: ____________

Consult Limitation: ____________

Prior Treatment: ____________

Current or pertinent medications: ____________

Clinical findings: ____________

Pertinent family history: ____________

Provider signature ____________ Specialty ____________ Date ____________ Phone ____________

3 — SPECIALIST REPORT

Physician findings and pertinent history: ____________

Laboratory, X-ray or other test findings: ____________

Medications added/changed: ____________

Treatment procedures: ____________

Additional Remarks: ____________

Disposition this visit (check **all** appropriate dispositions): Diagnosis: ____________ ICD-9 Code: ____________

___ No follow-up planned ___ Return if needed, prn ___ Referred to other Physician/Agency ___ Admit to Hospital

___ Return at Specified Time ___ Telephone follow-up planned ___ Return to Referring Physician ___ Other (specify) ____________

Has there been any telephone or personal contact made with the referring physician to