Charleston Area Medical Center

CAMC Outpatient Care Center Referral Form
3200 MacCorkle Ave SE
Charleston WV 25304

Please return the form completed with the items requested below to

REFERRAL FAX: 304-388-4837

DATE: _____ **REFERRING TO CLINIC**: _____

PATIENT NAME: _____ DOB _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

CONTACT NUMBER: _____ ALT. CONTACT NUMBER _____

INSURANCE_____ MEMBER ID _____ GROUP #_____

REASON FOR REFERRAL:

_____

_____

_____

REFERRING PROVIDER INFORMATION:

PROVIDER NAME _____ NPI _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

PHONE: _____ FAX _____

PLEASE SEND THE FOLLOWING WITH REFERRAL:

INSURANCE, MEDICAL IMAGING, LAB RESULTS, RECENT H&P, MEDICATION LIST

All referrals will be reviewed by our physicians before an appointment will be given.