

VASCULAR CENTER OF EXCELLENCE

3200 MacCorkle Ave. SE.
Charleston, WV 25304
(304) 388-8199
Toll free 1-866-655-7377
Fax: (304) 388-8195

VASCULAR
CENTER OF EXCELLENCE



**Charleston Area
Medical Center**

Date _____

All information MUST be complete for referral to be processed
It takes around 7-10 business days for an appointment to be scheduled

If you have an **ASAP** referral please mark here

- 1st Available Ali AbuRahma, MD John Campbell, MD
- Stephen Hass, MD Albier Mousa, MD A. Nanjundappa, MD
- Shadi Abu-Halimah, MD – **Charleston General Office**
- Mohit Srivastava, MD - **Teays Valley Office**

Reason for Referral/Diagnosis _____

Required Information

Fax recent H&P/Office notes, Lab Work, Vascular Testing, MRA, CT, Ultrasound, etc. for Referral to be processed

Patient Information

Last Name _____ First Name _____ MI _____

DOB _____ SSN _____ Marital Status (S/M/W/D) _____ Male/Female _____

Address _____ City _____ State _____ Zip Code _____

Home/Cell Phone _____ Work/Other Phone _____

Emergency/Privacy Contact _____ Relationship _____ Phone () _____

Referral Information

Referring Physician _____ Date of Last Visit _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Fax # _____ Contact Person _____

Copy of insurance card(s) required (Fax pre-certification on required insurances)

Ins Co _____ Policy # _____ Subscriber _____

Ins Co _____ Policy # _____ Subscriber _____

OFFICE USE ONLY:

Appointment for testing _____ **Appointment with Dr.** _____

Patient will be notified of date and time via US Mail Service