



# Physician Referral

at The Western Pennsylvania Hospital

IF THIS IS AN EMERGENCY, CALL 911. DO NOT USE THIS FORM FOR EMERGENCIES.

## Physician Resources

To refer one of your patients, you may call us at 1-866-680-0004 or complete this form to begin the patient referral process. A representative in your office will be contacted by one of our Referral Specialists to collect additional information. The patient will be contacted and the appointment confirmed.

Fax:  
412-359-3002

or Mail:  
The Western Pennsylvania Hospital  
4700 Friendship Avenue  
Pittsburgh, PA 15224  
Attn: Physician Referral

or call us:  
866-680-0004 • option 1 or  
412-578-5000

### About the referring physician

Name: \* \_\_\_\_\_

Street: \* \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Office Phone: \* \_\_\_\_\_

Office Fax: \_\_\_\_\_

Email: \_\_\_\_\_

### About the patient

Name: \* \_\_\_\_\_

Date of Birth: \* \_\_\_\_\_

Gender: \*  Male  Female \_\_\_\_\_

Street: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Daytime Phone: \* \_\_\_\_\_

Evening Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

## Diagnosis information

Diagnosis Date: \_\_\_\_\_

Diagnosis Method:

- Biopsy
- Lab Work
- CT Scan
- MRI
- Ultrasound
- X-Ray
- Cytology
- Other (please specify):

General diagnosis information: \*

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## Treatment information

Is the patient currently under treatment? \*

Yes  No

If patient is currently under treatment, describe the method of treatment:

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## Referral information

Are you referring to a specific physician? \*

Yes  No

If you are referring patient to a specific physician, provide physician's name: [\(find a physician online\)](#)

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One of our Referral Specialists will call your office to discuss this referral further and to obtain additional information pertinent to this patient. Please indicate the contact person who can best assist with this referral.

## About the referring physician

Same as physician information above?

Yes  No (if "no", please provide contact information below)

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Daytime Phone/Ext: \_\_\_\_\_



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## Additional comments

Your patient will also be contacted in order to review insurance coverage and obtain additional demographic information. Medical and financial eligibility will need to be established prior to confirming an appointment. If you would like to leave a message for our referral office, please type it here:

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All correspondence will receive a response within 24 hours excluding weekends and holidays. If you require immediate assistance, please call our referral office (Monday through Friday from 8:00 a.m. to 5:00 p.m. EST) at 1-866-680-0004.

If your situation is urgent, please call us at the number below. Otherwise, fax or mail the completed form to us.

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