Weight Loss Center

AFFILIATED WITH

Charleston Area Medical Center

REFERRAL FORM

Physician: Please circle one of the following: Dr. Shin Dr. Rossi or First Available Appointment

Date of Referral: ________________________________ Urgent (Circle one please) YES NO

Contact Person: _________________________________ Contact number: _______________________

Reason for referral:____

Referring physician: ____

Full Address:____

Office number:________________________________Fax number:_____________________________

E-mail address :____

NPI number: ____

PATIENT INFORMATION

Patient's Name ____DOB ______________________

SS # _____________________________________Phone Number ______________________________

Full Address ____

Insurance Coverage Name ____

Benefit number ____

Insurance ID # ____ Group # ____________________

Patient may attend a free seminar or do the online seminar if they are for a bariatric surgery patient. All patients will be notified of the appointment date and time. Thank you in advance for the referral. Please call your office if you have further questions at (304) 388-4965.