REFERRAL REQUEST

YOUR CHILD'S NAME: _____

CHILD'S DATE OF BIRTH: _____

INSURANCE PROVIDER: _____

CONTRACT NUMBER: _____

SPECIALIST'S NAME:

OR NAME OF FACILITY: _____

REASON CHILD IS BEING

REFERRED TO SPECIALIST: _____

_____

_____

TODAY'S DATE: _____

APPT. DATE OR DATES _____

DAYTIME PHONE NUMBER: _____

Our Physician has requested that you make an appointment for your child to be evaluated by the below medical specialist We recommend that you schedule this at a convenient time no later than ____/_____/_____. If the office is unable to accommodate you by this date please call our staff and we will assist you in scheduling the requested appointment.

Attach
Medical Specialist's
Card Here

Please return the top portion of this page to our office as soon as you have scheduled the appointment .

If your insurance requires referrals be submitted for approval ;our office will provide this service, then fax a copy to the above specialist. (please allow 3-5 days to process unless service needed is of an emergency nature)

We will also forward any medical records and tests results to the specialist. This may eliminate unnecessary duplication of costly tests in some cases.