**REQUEST FOR REFERRAL**

**BUCKINGHAM PEDIATRICS P.O. BOX 665 BUCKINGHAM, PA 18912**

**FAX: 215-794-9642 EMAIL to: Referral@bpeds.com**

**PARENTS ARE RESPONSIBLE FOR:**

**-Initiating referral requests**

**\*Providing NPI number from the specialist; referral cannot be processed without this information**

**-Please complete this referral request form and fax, mail, e-mail or drop off to our office a minimum of (3) days prior to your appointment.**

 **-A same day referral will be prepared on an emergency basis.**

 **-Telephone referrals are accepted on an emergency basis.**

**PARENT OR GUARDIAN PLEASE COMPLETE:**

**Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referral is for: (Please Circle One) Initial Consult Follow up Test**

**Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DX Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Specialist’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*NPI#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Hospital/Facility providing test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Location of Facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Test(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**APPOINTMENT DATE\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_**

**A referral must be authorized by a Buckingham Pediatrics physician.**

**Please circle one:**

**Dr. Moore Dr. Walsh Dr. Sharma**