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 Diane Alesi, CRNP Lisa Henderson, CRNP