BUCKINGHAM PEDIATRICS
4870 York Rd
Buckingham PA 18912

REQUEST FOR REFERRAL

When this form is completed in full
FAX: 215-794-9642 /215-794-3361
EMAIL: Referral@bpeds.com
Or drop off at the office

Our office requires 5 business days' notice
Emergency referrals can be backdated if necessary.
Parents Are Responsible for Initiating Referral Requests

PARENT OR GUARDIAN PLEASE COMPELTE:

Patient's Name_____Telephone#_____
D.O.B_____/_____/_____

Referral is for: Initial Consult _____ Follow up _____ Testing _____ Surgery ____

Insurance: _____ID#_____

Name of Specialist: _____Date of appoint/time: _____

Telephone#: _____Fax#: _____

Specialty: _____NPI#: _____

Place of Service: OFFICE, OUT PATIENT, IN PATIENT – (Please ask your specialist office)

Diagnosis or ICD 10: _____, _____, _____, _____.

Procedure Code: _____, _____, _____, _____.

This form must be completed in its entirety for us to issue a referral.

Please note that referrals are issued for current patients only. If you have not been seen for a well visit within the last 12 months a referral can't be issued, unless it is an emergency.

A referral must be authorized by a Buckingham Pediatrics physician. Please circle one:

Dr. Moore
Diane Alesi, CRNP
Lisa Henderson, CRNP
Hannah Tobin, PA