REFERRAL REQUEST FORM

Today's Date: _____

1. Have you verified with your insurance company that you need a referral for the problem that your child has?

   [ ] Yes [ ] No

   If no, please stop here and call your insurance company or read the information about your policy.

2. Have you received approval for this referral from your doctor or nurse practitioner?

   [ ] Yes [ ] No

   If no, please stop here and speak with your doctor or nurse practitioner.

3. Have you made an appointment with the specialist? [ ] Yes [ ] No

   If no, please stop here and call the specialist's office to make an appointment.

Please Print:

Child's Last Name: _____ First Name: _____

Child's Date of Birth: _____ Your Name: _____

Your Home Phone #: _____ Your Work/Cell#: _____ Your Email:

_____

Your Current Insurance Co.: _____

Your Child's Insurance ID#: _____

We must have your child's ID# INCLUDING all suffixes. We cannot process a referral without this.

Date of Your Child's Appointment with a Specialist: _____

Reason for Referral: _____

Specialist's Full Name: _____

Specialist's NPI#: _____

We must have this number and cannot issue a referral without it. You may obtain this number by calling the Specialist.

Please list your diagnoses and if injury be specific (Ex.: Right arm)_____

Specialist's Address (of Hospital Address): _____

City or Town: _____ Zip Code: _____

Specialist's Phone Number: _____ Fax #: _____

Who is your primary care doctor? – Circle One

Dr. Bruce Bunnell Dr. Tracey Daley Dr. Parag Amin

Dr Laura De Girolami Dr. Michael Ma Dr. Caitlin King

Please mail, fax, email or bring this to:

Centre Pediatric Associates, PC
Attn: Referrals
One Brookline Place, Suite 327
Brookline, MA 02445

Telephone: (617)-735-8585
Fax: (617)-232-0572

Email: sabdulbasir@mgb.org

Or submit this form via our web site at www.centrepediatrics.org