

REFERRAL REQUEST FORM

Today's Date: _____ Your Centre Pediatrics' Physician: _____

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#: _____ Fax#: _____

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

Dr. Laurel Gaffin

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