PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

6355 Walker Lane • Suite 401 • Alexandria, Virginia 22310 • 703-924-2100 • Fax 703-924-9894

REFERRAL REQUEST FORM

Please allow 3-5 business days for all referrals to be processed. Before scheduling an appointment with a specialist you must confirm that it is a participating provider with your insurance company. Out-of-network referrals will not be processed for specialist visits.
When scheduling your child's follow-up appointment ask the specialist office if you will be needing a new referral for the scheduled visit.

******BACK DATED REFERRALS WILL NOT BE CREATED*******

PARENT/GUARDIAN//FRONT DESK

Date:_____ Time:_____

Patient's Name: _____DOB _____
Last First

Insurance Co. _____ Policy ID#:_____

Parent Name:_____ Telephone No. _____

Specialist Name:_____ _____ Specialty:_____
Last First

Appointment Date:_____ Time:_____ Tel.#_____

Reason For Visit (Diagnosis):_____ ___Initial Visit ___Follow-up Visit

Once the referral is completed it can be: ____Picked up or ____Mailed

Mailing Address: _____

_____

Referrals will no longer be faxed; specialist offices are requesting original hard copy of referrals to be brought to appointments.

*** Staff Completing Form:_____ Provider's Initials Approving Request:_____

AUTHORIZATION FOR PICK UP

Date:_____ Time:_____

Parent able to pick up referral(s):
Mother's Name:_____ **Father's Name:**_____
Legal guardian able to pick up form if not parent: **Court Papers in File:**
Full Name:_____ _____
NOTES:_____ Supervisor Authorizing pick up: _____

PICKING UP FORM
Date:_____ Time:_____

Signature of Parent/Guardian:_____ **Print Name:**_____

Name of Staff Giving Parent Form:_____