PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

6355 Walker Lane ● Suite 401 ● Alexandria, Virginia 22310 ● 703-924-2100 ● Fax 703-922-6067

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 their next scheduled visit.

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

Parent/Guardian

Please complete this form in its entirety. Thank You.

Date:______________________ Time:___________________

Patient's Name:________________ ______________________ DOB:___________________
Last First

Insurance Co.__________________________ Policy ID #:________________________________

Parent Name:______________________________ Contact #:______________________________

Specialist Name:__________________________________ Specialty: ______________________

Specialist Address:____

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: _____________________________________

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****Most specialist offices are requesting original hard copy of referrals to be brought to appointments, some offices will make an exception and accept a fax copy, please provide the specialist fax number:_______________________**