Referral Request Form

Brookline Pediatrics
Boston Children's
Primary Care Alliance

brooklinepediatrics.com
617-232-2915 | *fax* 617-232-2337

Today's date: _____

Patient information

Last name: _____

First name: _____

Date of birth: _____

Your child's Brookline Pediatrics physician:

_____

Questions about your referral

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.

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.

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.

Parent/Guardian information

Your name: _____

Phone: _____ ❍ Home ❍ Work ❍ Cell

Phone: _____ ❍ Home ❍ Work ❍ Cell

Phone: _____ ❍ Home ❍ Work ❍ Cell

Fax: _____

Your current insurance company:

_____

Your child's insurance ID#: _____

We must have your child's complete ID#, including all numbers and letters, to process your referral.

Specialist information

Date of your child's appointment with a specialist:

_____

Reason for referral:

_____

_____

_____

_____

Specialist's full name: _____

Specialist's NPI#: _____

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

Specialist's hospital/practice:

_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

Your Brookline Pediatrics provider

Brookline Pediatrics doctor or nurse who diagnosed your child and suggested and/or approved this referral:

_____