iPediatrics
21 Bowling Green Parkway, Suite 202
Lake Hopatcong, NJ 07849
(973) 663-1143 / fax 973-810-3233

REFERRAL REQUEST

*ALL INFORMATION MUST BE COMPLETED FOR REQUEST TO BE APPROVED
*PLEASE ALLOW AT LEAST 1 WEEK NOTICE FOR ALL NON EMERGENCY REQUESTS

PATIENT INFORMATION

Date of Request	Patient Name	Date of Birth

Address	Phone

Insurance Company	Insurance ID Number

Subscriber/Policy Holder of Above Mentioned Insurance

WHO RECOMMENDED THIS REFERRAL?

REFERRAL IS NEEDED FOR WHICH PHYSICIAN/TEST?

Name

Doctors' or Testing Center Address	Doctor/Testing Center Phone

Date of Appointment	Total Number of Visits Requested	**Doctor's/Testing Center's Insurance ID#**

HAS THE ABOVE MENTIONED PHYSICIAN SEEN THIS PATIENT FOR THIS SAME MEDICAL CONDITION

YES NO

WHEN REFERRAL IS COMPLETED, I PREFER TO HAVE THE COMPLETED REFERRAL (PLEASE CIRCLE ONE)

MAILED TO ME (Self Addressed stamped envelope must be provided) OR PICKED UP BY ME

FOR OFFICE USE ONLY

Received By/Date	Approved By/Date	Processed By/Date

DX/ICD9	Number of Visits