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: ___________________________________

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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:_______________________________________