PEDIATRIC SURGICAL ASSOCIATES
GENERAL, THORACIC & MINIMALLY INVASIVE SURGERY
*every child deserves our best*

# REFERRAL FORM

**PLEASE PRINT**

Patient's Full Legal Name:______________________________________________
Last First Middle Preferred Name

Patient's Address:______________________________________________
Street City State Zip Code

Home Phone: ( )____________________________ Age:_________ Birth Date:_______________________ Sex _____M _____F

Referring Doctor: ______________________________________________
Name Practice Name/ Hospital Affiliation Phone # Fax #

Chief Complaint or Problem: ______________________________________________

| Parent / Guardian |
|---|
| Name: |
| SS#: |
| Relation to Patient: |
| Home Phone#: ( )<br>Cell Phone #: ( ) |
| Business Phone: |

**Primary Insurance**:_____________________________________ Phone#:_____________________

Policy Number/SS# of Subscriber:_____________________________ Group Name/ #:_________________

Subscriber's name & DOB:___________________________________ Authorization Required:_____________

**Secondary Insurance**:___________________________________ Phone#:_____________________

Policy Number/SS# of Subscriber:_____________________________ Group Name/ #:_________________

Subscriber's name & DOB:___________________________________ Authorization Required:_____________

**Urgency of Appointment (Check One):**

- ☐ Emergency (within 24 hours) Please call our office for urgent appointments.
- ☐ Soon (1-2 weeks) Fax all related reports regarding nature of consult.
- ☐ Routine (4-8weeks) Fax all related reports regarding nature of consult.

**Doctor Requested:**

- ☐ *First Available*
- ☐ Daniel A. Bambini, M.D.
- ☐ Andrew M. Schulman, M.D.
- ☐ Graham H. Cosper, M.D.
- ☐ Thomas M. Schmelzer, M.D.
- ☐ Nicholas E. Bruns, MD

Referral made by: ____________________ Phone:__________________ Fax:_________________ Email:_____________________

*'Fax completed form to Pediatric Surgical Associates 704-370-0799*

**Records must be received before processing referral**

**OFFICE USE ONLY**

**Scheduled Appointment**

**Date:_________________ Time:__________ Dr:_____________________ Parents Notified:_________**