Patient Referral Request

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Pediatric & Adolescent Medicine
49 Derry Road (Route 102)
Hudson, NH 03051-4027

Phone 603-889-4422 Fax 603-889-5544

Please fill in all the areas of this form including a signature of the person making the request. Then fax it to the office at 603-889-5544 (at this time privacy regulations due not allow emailing patient information on an insecure web site server). If you have not heard back from the office within 5 business days, please call to be sure we have received the information. You may also use the after-hours office phone messaging to leave a refill or referral request, please include all the information listed on this form. If the referral is needed immediately, please call the office.

Patient's name: _____ Birth date: _____

Person making request: _____

Contact phone number: _____

Specialist's / Provider's Name: _____

NPI (national provider identification number): _____

Specialty: _____

Address: _____
Street/Suite City/Town State Zipcode

Phone: _____Fax: _____

Appointment date(s): _____ Number of visits: _____

Reason for visit(s): _____

Insurance Company: _____

Insurance ID number: _____ Insurance type: HMO / PPO/ POS

Your signature: _____ Date: _____

Please remember that this office does not decide coverage for a specialty visit but that your insurance company has the final determination. We advise you to contact your insurer prior to your visit to be assured that the visit will be covered. If your visit requires other information (e.g. office notes, radiology films, laboratory test results), please give us enough time to help you put the information together.