# REQUEST FOR REFERRAL

**Doylestown Family Medicine**
**300 Spruce Street**
**Doylestown, PA 18901**
**FAX 215-230-7993**

**PATIENTS ARE RESPONSIBLE FOR:**

- Initiating referral requests
- For getting specialists provider number: This is needed to complete all referrals.
- Please complete this referral request form and fax, mail or drop off to our office prior to your scheduled appointment. Telephone referrals are accepted at any time.

**PATIENT, PARENT OR GUARDIAN COMPLETE:**

**Patient's Name** _____

**D.O.B.** ____-____-_____ **Telephone Number**____-____-_____

**Insurance** _____ **ID Number**_____

**Referral is for: (Please Circle One)** **Initial consult** **Follow up visit** **Test**

**Diagnosis** _____

**Specialist Name** _____

**Specialists Provider Number** _____

**Phone Number** ____-____-_____ **Fax Number** ____-____-_____

**Name of Hospital/Facility providing test** _____

**Name and/or test number for Test(s)**

_____

**APPOINTMENT DATE** _____/_____/_____
MONTH DAY YEAR

**Please Sign Here** _____
**Signature of Patient, Parent or Guardian**