Children's DIRECT
Phone: 1-800-678-4357
Fax: 314-747-1902
Email: Childrens_Direct@BJC.org

Pediatric Specialist Appointment Referral Form

Fax to: 314-747-1902

All fields are required to register the patient, otherwise scheduling may be delayed.

Please complete the form below and fax it to 314-747-1902 along with:

- ***Office Notes**
- ***Any recent Labs/Imaging Reports/Test Results**
- ***Other Relevant Patient Records**
- ***A clear copy of the Insurance Card**
- ***For GI/Endo referrals, please also include Height/Weight Growth Charts.**

REFERRING OFFICE INFO:

PCP: _____

Referring Provider: _____

Person completing the form: _____

Office Phone: _____ EXT: _____ Office Fax:_____

PATIENT INFO:

Patient Name: _____ **M / F** DOB: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Alternate Phone: _____

PARENT INFO: For ALL patients, must have parent name & DOB. For private insurance, parent listed must be the one who holds the insurance. PO Box/Zip Code only required for non-Medicaid plans.

Parent Name: _____ Relation: _____ DOB: _____

Insurance: (include HMO, PPO, etc.) _____

Member ID: _____ Group #: _____

PO Box Number for Mailing Claims: _____ Zip Code: _____

REFERRAL INFORMATION: Please write out the diagnosis rather than listing the ICD code.

Department: _____ Dx: _____

Department: _____ Dx: _____

Department: _____ Dx: _____

Interpreter Needed? (Specify Language): _____ Drive time to St. Louis: _____

Other Scheduling Requests: _____