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

Directions: All fields are required to register the patient, otherwise scheduling may be delayed. Please complete the form below or attach a face sheet that includes the requested info.

PCP: _____

Referring Provider: _____

Person completing the form: _____ Date:_____

Office Phone: _____ EXT: _____ Office Fax:_____

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. (Email is optional.)

Parent Name: _____ Relation: _____ DOB: _____

Employer: _____ Email: _____

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

Member ID: _____ Group #: _____

Mailing Address for Claims: _____ ZIP: _____

Customer/Provider Services Phone #: _____

Referral Information: Please attach office notes, any recent labs/imaging reports, other relevant patient records, and a clear copy of the insurance card. For GI/Endo, please include growth charts.

Department: _____ Dx: _____

Department: _____ Dx: _____

Department: _____ Dx: _____

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

Other Scheduling Requests: _____