Patti's PLACE
Vital Pediatrics for Complex Kids, LLC

Patient Name: _____

Date of Birth: _____

Phone: 404-986-8756 | Fax: 404-986-0803

REFERRAL FORM

PATIENT INFORMATION Date:

First Name: MI: Last Name:

Address:

City: State: Zip:

INSURANCE INFORMATION **Please complete or attach a copy of the primary insurance card.**

Insurance Company: Group Name or Number:

Subscriber ID #: Benefits & Eligibility Phone #:

Primary Insured (if not patient): Date of Birth for Primary Insured:

REFERRAL REASON

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☐ Yes ☐ No Is Patient aware of diagnosis? ☐ Yes ☐ No

REFERRING PRACTICE

Referring Provider Name: Practice Name:

Referral Coordinator: Phone #:

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Vital Pediatrics for Complex Kids/Patti's Place Use ONLY

Appt. scheduled with: Date: Time:

Appt. info faxed to referring practice ☐ Yes ☐ No Date: By: