UB|MD PEDIATRICS

NEW PATIENT REFERRAL FORM

Please complete the following and fax to the Division of Gastroenterology at 716.323.0295.

Patient Name: _____ DOB: _____/_____/_____

Parent/Guardian: _____ Phone: _____

Address: _____ City: _____ State: _____

Referring Provider: _____

Phone: _____ Fax: _____

☐ **Check if patient has a signed Health-E-Link agreement on file**

Insurance: _____ Member #: _____ Group: _____

Medicaid CIN #: _____

Guarantor: _____

Guarantor SS # (last four): _____ Guarantor's DOB: _____/_____/_____

Insurance Authorization (if required): _____

PLEASE SEND: IMMUNIZATION RECORD, GROWTH CHART, LAST PROGRESS NOTES, CURRENT LABS, RADIOLOGY REPORTS, AND PERTINENT INFORMATION.

Reason for Referral:

☐ **Please call parent to schedule appointment.**

☐ **Appointment date given to parent:** _____ _____
Date Time

THREE OFFICE LOCATIONS

☐ Conventus, 1001 Main Street, 4th Floor, Buffalo, NY 14203
☐ University Commons, 1404 Sweet Home Road, Suite 5, Amherst, NY 14228
☐ Southwestern Office Park, 4535 Southwestern Blvd., Suite 712, Hamburg, NY 14075

Division of Gastroenterology
(Digestive Diseases & Nutrition Center)
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