UB|MD PEDIATRICS

NEW PATIENT REFERRAL FORM

Please complete the following and fax to the Division of Pulmonology at 716.323.0296.

Patient Name: _____ DOB: _____/_____/_____

Referring Provider: _____

PMD (if different than above): _____

Phone: _____ Fax: _____

Reason for Referral:

Additional Comments:

Please complete this form and fax it back to our office at 716.323.0296. Be sure to include all recent lab work and other testing.

If you need to reach our office, please call 716.323.0110. Thank you for your referral.

Division of Pulmonology
1001 Main Street, 5th Floor | Buffalo, NY 14203 | T: 716.323.0110 | F: 716.323.0296 | UBMDPediatrics.com