**PEDIATRIC ASSOCIATES OF RICHMOND,INC.**
**CALL CENTER 804 282-4205**

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Kristin Flohre, R.N.,C.P.N.P.

# PREVIOUS DOCTOR MEDICAL REQUEST

Date:_____

**PREVIOUS DOCTOR:**

Name:_____

Address:_____

_____

_____

Phone Number:_____

Fax Number:_____

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**DEAR DOCTOR(S);**

Please send medical records for the child/children listed below:

NAME:_____D.O.B._____

NAME:_____D.O.B._____

NAME:_____D.O.B._____

NAME:_____D.O.B._____

Please send the following information on the listed patient(s):

_____Shot Record

_____Most Recent Physical

_____All Medical Records

Records should be sent to the:

_____Three Chopt Office (Fax: 804-673-6432) _____Bell Creek Office (Fax: 804-559-9227)

Patient's Signature (If 18 years of age or older):_____Date:_____

Parent or Guardian Signature:_____Date:_____

OR

Requesting Provider's Signature:_____Date:_____