Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Referral Request Form

Attn: Maria Chavez
Salinas/Capitola Tel: (831) 757-7722 Fax: (831) 757-7733

Fetal Cardiology Outpatient Referral Form

** You can register for Stanford Children's Health MD Portal (https://mdportal.stanfordchildrens.org) to submit referrals and track appointments online.*

◯ **Medically URGENT/PRIORITY**

◯ Routine

Referring Provider

Referring MD/NP/PA: _____ (LAST NAME) _____ (FIRST NAME) (___) ___ - ____ (TELEPHONE) (___) ___ - ____ (FAX)

Please indicate your relationship to the patient: ◯ PCP ◯ Other: _____ (SPECIALTY)

_____ (FORM COMPLETED BY) __/__/____ (DATE)

Reason for Referral

If you would like an MD Consult regarding this referral please call (831) 757-7722.

Reason for visit: ◯ New Patient Consultation ◯ 2nd Opinion ◯ Transfer of Care ◯ Procedure/Surgery (no consultation needed)

**Please note: A referral is not required for follow up patients with the same diagnosis if they have been seen in the last 3 years.*

Please contact the clinic directly to schedule a follow up appointment.

Service/Specialty Requested: Fetal cardiac consultation/echo Provider Requested: Dr. Anna Harbison

ICD10 (**Required**): Letter Number | Letter or Number ____.____ (min 3 & max 7 characters) EDD: _____

Reason for Referral:

_____

_____

_____

_____

_____

Please fax all relevant clinical documents (i.e. clinic notes, history and progress notes, medication history, diagnostic reports and a copy of the insurance card)

Please remember to fax authorization.

Required Patient Information

Interpreter required for either patient or parent/guardian? ◯ Yes ◯ No _____ (PATIENT LANGUAGE) _____ (PARENT/GUARDIAN LANGUAGE)

_____ (LAST NAME) _____ (FIRST NAME) _____ (MIDDLE NAME)

Date of Birth: __/__/____ Age: _____

Patient's Address: _____ City/State/Zip: _____

Patient's Phone: (___) ___ - ____ (HOME/CELL/WORK) Alternate Phone: (___) ___ - ____ (HOME/CELL/WORK)

Guardian Name: _____ Guardian Relationship: _____

Insurance Information

◯ Self Pay **PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED.**

Guarantor same as Subscriber? ◯ Yes ◯ No

Guarantor: _____ (PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) Guarantor Relationship: _____

Guarantor DOB: __/__/____

Authorization Required: ◯ Yes ◯ No Auth#: _____ Authorization Expiration Date: __/__/____