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

Referral Request Form
Attn: Referral Center
Tel: (800) 995-5724 Fax: (650) 721-2884

CENTER FOR HEALTHY WEIGHT

*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: __/__/____ (mm/dd/yyyy)

Select the Appropriate Clinic/Program

☐ **Pediatric Weight Control Program (Family-based Group Program)**
- NO REFERRAL NEEDED. Patient/parent can call directly to enroll (650) 725-4424
- BMI must be ≥ 95% or ≥ 85% with a comorbidity
- 6 month weekly family group sessions promoting lifestyle/ behavior changes
- Children and adolescents 8-15 (Groups in English and Spanish)

☐ **Nutrition Clinic (self pay)**
- Dietitian/Nutritionist (RDN) consultation
- Individualized nutritional treatment
- For ages 0-18
- Needs a REFERRAL from PCP

☐ **Pediatric Weight Clinic**
- Multidisciplinary consultation
- Individualized medical and nutritional treatment
- BMI must be ≥ 99% or ≥ 30
- For ages 0-18
- Needs a REFERRAL from PCP

☐ **Adolescent Bariatric Surgery Program**
- Multidisciplinary evaluation
- Individualized medical/surgical and nutritional treatment
- BMI must be ≥ 40 or ≥ 35 with a major comorbidity and age must be ≥ 10
- First appointment will be a group teaching session.
- Needs a REFERRAL from PCP

Referral Diagnosis and ICD-10 (**Required**):

☐ Overweight (E66.3) ☐ Obesity (E66.9) ☐ Severe obesity (E66.01)

☐ Other (specify): _____

Patient information (required)

BMI = _____ BMI percentile = _____

Comorbidities:

☐ Anxiety
☐ Depression
☐ Diabetes type 2
☐ Dyslipidemia
☐ Fatty liver
☐ Hyperinsulinemia
☐ Hypertension
☐ Insulin Resistance
☐ OSA (Obstructive sleep apnea)
☐ PCOS (polycystic ovary syndrome)
☐ Pre-diabetes
☐ Pseudotumor cerebri
☐ SCFE (Slipped capital femoral epiphysis)
☐ Vit D deficiency
☐ Other: _____

Please fax all relevant clinical documents

(i.e. clinic notes, history and progress notes, medication history, growth charts, labs, diagnostic reports and a copy of the insurance card)

Required Patient Information

◯ Female ◯ Male Stanford Children's Health Medical Record: _____

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: (____) _____ - _____ Alternate Phone: (____) _____ - _____

Guardian Name: _____ Guardian Relationship: _____

Insurance Information

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

◯ Self Pay Guarantor same as Subscriber? ◯ Yes ◯ No Guarantor: _____ (person financially responsible for patient)

Guarantor Relationship: _____ Guarantor DOB: __/__/____

Authorization Required: ◯ Yes ◯ No #Visits Authorized: _____ Auth#: _____

Authorization Expiration Date: __/__/____

REVISED 03/2019