Stanford MEDICINE
Children's Health

Referral Request Form

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

Motion and Gait Analysis

** 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 ______ ext TELEPHONE ______ FAX

Please indicate your relationship to the patient: ◯ PCP ◯ Other: ______ SPECIALTY

______ FORM COMPLETED BY ______ DATE

Reason for Referral

**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 at (650) 723-5308.

Reason for Referral: ☐ Lower Extremity Gait Test ☐ Upper Extremity Gait Test

Letter Number Letter or Number

ICD10 (**Required**): [ ][ ][ ] . [ ][ ][ ][ ] (min 3 & max 7 characters)

Reason for Referral: ______

Specific Problems: ______

Treatment Considerations: ______

If URGENT please provide reason: ______

Please remember to fax authorization.
Gait Analysis CPT codes to check for Prior Auth - 96000, 96004, 97161, 97162, 97163, and 97750

Required Patient Information

◯ Female ◯ Male Stanford Children's Health Medical Record: ______ (IF AVAILABLE)

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 (circle/click) Alternate Phone: ______ HOME | CELL | WORK (circle/click)

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

Guarantor DOB: ______

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

Authorization Expiration Date: ______