

Pediatric Pain Management Clinic

* 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/DO/NP/PA: _____
LAST NAME FIRST NAME TELEPHONE ext FAX

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

FORM COMPLETED BY _____

DATE _____

Reason for Referral

During your patient's initial clinic appointment a team of pain management specialists consisting of a physician, nurse practitioner, child psychologist, and pediatric physical therapist will evaluate your patient.

Type of Visit: New Patient Consultation New Patient Consultation and Ongoing Management of Pain

Physician Requested, if any: Next Available Berger Dinh D'souza Golianu Krane Kwon McGinn

*Please note: A referral is not required for follow up patients with the same diagnosis if they have been seen in the last 2 years.

Please contact the clinic directly to schedule a follow up appointment at (650) 497-8977.

Pain Diagnosis: _____

ICD10 (Required):

↓ Letter	↓ Number	↓ Letter	↓ Number	↓ Letter	↓ Number	↓ Letter	↓ Number

 (min 3 & max 7 characters)

Reason for Referral: _____

Procedures or Interventions, if any: _____

Records in EPIC? Yes No—please fax all relevant clinical documents (i.e. history/progress notes, specialty clinic notes, medication history, growth charts—height and weight, labs, diagnostic reports, insurance authorization, and copy of the insurance card) to (650) 721-2884.

Required CPT Codes to be Authorized for all New Patient Consult Request:

99245 New Patient MD Outpatient Consultation **96150** New Patient Psych Evaluation **97001** New Patient Physical Therapy Evaluation

Required Patient Information

Female Male Other

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: _____

Alternate Phone: _____

HOME | CELL | WORK (circle/click)

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: _____