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

Referral Request Form

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

General 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 the Referral Center at (800) 995-5724.

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: _____ Provider Requested: _____

ICD10 (**Required**): Letter Number __ __ __ . Letter or Number __ __ __ __ (min 3 & max 7 characters)

Reason for Referral: _____

Please fax all relevant clinical documents (i.e. clinic notes, history and progress notes, medication history, growth charts-height and weight, head circumference, labs, diagnostic reports and a copy of the insurance card)

Please remember to fax authorization.

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

Guarantor DOB: __ __ / __ __ / __ __ __ __

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

Authorization Expiration Date: __ __ / __ __ / __ __ __ __