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

Referral Request Form

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

Pediatric Sleep Center

** 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)

_____ (REFERRING PROVIDER SIGNATURE (**REQUIRED**)) _____ (FORM COMPLETED BY) _____ (DATE)

Type of Service Requested (all procedures done per LPCH Sleep Center protocol)

	6 Years or Older	Under 6 Years	Additional
☐ Polysomnogram Diagnostic Baseline	95810-26	95782-26	
☐ Polysomnogram + CPAP/BiLevel	95811-26	95783-26	
☐ Polysomnogram + Oxygen Titration	95810-26	95782-26	
☐ Polysomnogram + pH/Impedance Probe Study	95810-26	95782-26	pH probe 991034
☐ Mask Fitting and CPAP Acclimation (PAP-NAP)	95811-26	95783-26	
☐ Polysomnogram diagnostic with seizure montage	95810-26	95782-26	

☐ Ventilator/NIPPV Titration *(ordered only by Pulmonary MD)*

Current Settings (Ventilator/CPAP/Bi-level)/Comments:

_____

_____

LPCH Pulmonary/Sleep Physician Consultation

Consultation with LPCH Pulmonary/Sleep Physician
Please Check One

☐ Before Polysomnogram (sleep study)
☐ After Polysomnogram
☐ Consultation Only

Note: Physician Consultations are scheduled through the LPCH Pulmonary Clinic. Consultations requested before Polysomnogram may delay study.

Reason for study: (REQUIRED)

☐ ADHD (F909)
☐ ALTE (R6813)
☐ Asthma (J45909)
☐ BPD (P271)
☐ Craniofacial Disorder (Q75.9)
☐ Cystic Fibrosis (E840)
☐ Daytime Hypersomnolence (G4710)
☐ Decannulation (J39.8)
☐ Down Syndrome (Q909)
☐ Enuresis (N3944)
☐ Myelomeningocele (Q059)
☐ Narcolepsy (G47419)
☐ Nocturnal Arousals (F518)
☐ Obesity (E668)
☐ Observed Apnea (G4733)
☐ Prader-Willi Syndrome (Q871)
☐ Pulmonary Hypertension (I272)
☐ Snoring (R0683)
☐ Other: _____

Please fax all relevant clinical documents (i.e. history, progress notes, diagnostic sleep studies, etc).

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: _____ (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: _____