

Developmental – Behavioral Pediatrics

* 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

Reason for visit: New Patient Consultation 2nd Opinion Transfer of Care

Is the patient a High Risk Infant Follow-up (HRIF)? Yes No

*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) 725-8995.

If Premie: Gestational age at birth: _____ NICU born at: _____ Birth weight: _____

ICD10 (Required):

↓ Letter	↓ Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number

 (min 3 & max 7 characters)

If not HRIF – Reason for Referral, what is the consult question? _____

A patient questionnaire is required for all patients 2 years 7 months and older:

Questionnaire provided to patient/family/guardian? Yes No

Foster Care Clinic Referral? Yes No

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:

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

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

Authorization Expiration Date:

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