

## Interventional Radiology Referral Form

\* You can register for Stanford Medicine Children's Health MD Portal (<https://mdportal.stanfordchildrens.org>) to submit referrals and track appointments online.

☐ **Medically URGENT/PRIORITY** ☐ Routine

### Required Patient Information

☐ Female ☐ Male ☐ Other

Stanford Children's Medical Record: \_\_\_\_\_ (IF AVAILABLE)

LAST NAME

FIRST NAME

MIDDLE NAME

Interpreter required for either patient or parent/guardian? ☐ Yes ☐ No

PATIENT LANGUAGE

PARENT/GUARDIAN LANGUAGE

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: \_\_\_\_\_

### Referring Provider

Referring MD/NP/PA: \_\_\_\_\_  
LAST NAME FIRST NAME ext TELEPHONE FAX

Please indicate your relationship to the patient: ☐ PCP ☐ Other: \_\_\_\_\_  
SPECIALTY

Provider Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

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 ☐ Procedure - Please Specify

\*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.

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

ICD10 (**Required**): \_\_\_\_\_ (min 3 & max 7 characters)

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please fax all relevant clinical documents**

(i.e. clinic notes, history and progress notes, medication history, labs, diagnostic reports, including film library or CD)

**Please remember to fax authorization.**

### Insurance Information

☐ Self Pay **PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED.**

Authorization Required: ☐ Yes ☐ No Auth#: \_\_\_\_\_ Authorization Expiration Date: \_\_\_\_\_