Stanford MEDICINE
Children's Health

# Referral Request Form

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

# Pediatric Pulmonology

** 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

## Referring Provider

Referring MD/NP/PA: _____ (LAST NAME) _____ (FIRST NAME) _____ ext (TELEPHONE) _____ (FAX)

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

_____ (FORM COMPLETED BY) _____ (DATE)

## Reason for Referral

Type of Visit: ◯ New Problem-Consultation ◯ Chronic Problem ◯ 2nd Opinion ◯ Procedure/Surgery (no consultation needed)
◯ Transfer of Care from another Pulmonologist ◯ Other, please specify: _____

Scheduling Preference: ◯ First Available ◯ Preferred Stanford Children's Pulmonologist (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 at (650) 724-4788.*

### Reason for Referral

- ☐ Apnea-Obstructive Sleep Apnea
- ☐ Apnea-Central Apnea
- ☐ Asthma
- ☐ BiPAP or CPAP patient
- ☐ Bronchopulmonary dysplasia
- ☐ Chronic Cough
- ☐ Chronic Lung Disease
- ☐ Cystic Fibrosis
- ☐ Neuromuscular Disorders
- ☐ Noisy Breathing
- ☐ Pneumonia-recurrent or persistent
- ☐ Respiratory Distress
- ☐ Restrictive lung disorder (scoliosis)
- ☐ Sleep disordered breathing
- ☐ Tracheostomy and/or ventilator
- ☐ Wheezing
- ☐ Other, please describe _____

### Required Clinical Information

Please FAX information below along with referral:

- ☐ History of current problem
- ☐ Relevant clinic notes for one year (spirometry, RAST, and total IGE)
- ☐ All medications and therapies (and response)
- ☐ All urgent care and ED visits
- ☐ All hospitalization discharge summaries
- ☐ All laboratory reports
- ☐ All Radiographs (chest x-rays) and reports

*** Hand carry actual films or discs ***

Duration of symptoms? ☐ Days_____ ☐ Weeks_____ ☐ Months_____ ☐ Years_____

**If URGENT please provide reason:** _____

## Required Patient Information

◯ Female ◯ Male ◯ Other Stanford Children's 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: _____