Stanford MEDICINE
Children's Health

Referral Request Form

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

Pediatric Pain Management Clinic

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

◯ **Medically URGENT/PRIORITY**

◯ Routine

Referring Provider

Referring MD/DO/NP/PA: _____ _____ ext _____ _____
LAST NAME | FIRST NAME | TELEPHONE | FAX

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

_____ _____
FORM COMPLETED BY | DATE

Reason for Referral

During your patient's initial clinic appointment a team of pain management specialists consisting of a physician, nurse practitioner, child psychologist, and pediatric physical therapist will evaluate your patient.

Type of Visit: ◯ New Patient Consultation ◯ New Patient Consultation and Ongoing Management of Pain

Physician Requested, if any: ◯ Next Available ◯ Borucki ◯ Dinh ◯ D'souza ◯ Golianu ◯ Kwon ◯ McGinn

**Please note: A referral is not required for follow up patients with the same diagnosis if they have been seen in the last 2 years. Please contact the clinic directly to schedule a follow up appointment at (650) 497-8977.*

Pain Diagnosis: _____

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

Reason for Referral: _____

Procedures or Interventions, if any: _____

Records in EPIC? ◯ Yes ◯ No—please fax all relevant clinical documents (i.e. history/progress notes, specialty clinic notes, medication history, growth charts-height and weight, labs, diagnostic reports, insurance authorization, and copy of the insurance card) to (650) 721-2884.

Required CPT Codes to be Authorized for all New Patient Consult Request:

99245 New Patient MD Outpatient Consultation **96150** New Patient Psych Evaluation **97001** New Patient Physical Therapy Evaluation

Required Patient Information

◯ Female ◯ Male ◯ Other Stanford Medicine 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: _____ Alternate Phone: _____
HOME | CELL /|WORK (circle/click) 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 _____ Guarantor Relationship: _____
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT)
Guarantor DOB: _____

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

Authorization Expiration Date: _____