Stanford MEDICINE
Children's Health

Referral Request Form

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

Genetics

* *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

____________ REFERRING PROVIDER SIGNATURE (**REQUIRED**) ____________ 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.
Request authorization for an MD consult (CPT 99245) and a genetic counseling visit (CPT 96041 = Private Insurance, CPT S0265 = MediCal/MediCare)

Reason for visit: ◯ New Patient Consultation ◯ 2nd Opinion ◯ Transfer of Care ◯ Procedure/Surgery (no consultation needed)

**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.

Service/Specialty Requested: ____________ Provider Requested: ____________

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, growth charts-height and weight, head circumference, labs, diagnostic reports and a copy of the insurance card)

Required Patient Information

◯ Female ◯ Male 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: ____________ 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: ____________