Stanford Children's Health | Lucile Packard Children's Hospital Stanford

# Referral Request Form

Attn: Referral Center
Tel: (800) 995-5724 Fax: (650) 721-2884
E-mail: referral@stanfordchildrens.org

## Motion and Gait Analysis Laboratory

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

◯ **Medically URGENT/PRIORITY** — call Referral Center to expedite: (800) 995-5724

◯ 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

**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) 723-5308.*

Reason for Referral: ☐ Lower Extremity Gait Test ☐ Upper Extremity Gait Test

Letter Number Letter or Number

ICD10 (**Required**): ___ ___ ___ . ___ ___ ___ ___ (min 3 & max 7 characters)

Reason for Referral: ______

______

Specific Problems: ______

Treatment Considerations: ______

**If URGENT please provide reason:** ______

**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: ___/___/_____ 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 ______ (PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) Guarantor Relationship: ______ Guarantor DOB: ___/___/_____

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

Authorization Expiration Date: ___/___/_____