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

Child Neurology

** 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

Reason for visit: ◯ New Problem–Consultation ◯ Chronic Problem ◯ 2nd Opinion ◯ Transfer of Care to another Neurologist

◯ Other, please specify: _____

Scheduling Preference: ◯ First Available ◯ Preferred Stanford Children's Health Neurologist (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) 723-0993.

Diagnosis

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

- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Developmental Delay
- ☐ Epilepsy
- ☐ Headaches
- ☐ Movement Disorders
- ☐ Neuromuscular Disorders/ Muscle Disease
- ☐ Seizures
- ☐ Tics

Test Previously Completed

- ☐ Brain MRI
- ☐ Head CT
- ☐ EEG
- ☐ Other: _____

The Neurology Clinic new patient scheduler will call your patient within one week of receiving this form to schedule their appointment.

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

Duration of symptoms? ☐ Days _____ ☐ Weeks _____ ☐ Months _____ ☐ Years _____

If URGENT please provide reason: _____

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: ___/___/_____