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

Pediatric Pain Management Clinic

** 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

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 ◯ D'Souza ◯ Golianu ◯ Krane ◯ Naidu

**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) 725-5848.*

If you would like an MD Consult regarding this referral please call the Referral Center at 1-800-995-5724

Pain Diagnosis: ______

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

Reason for Referral: ______

Procedures or Interventions, if any: ______

Please fax all relevant clinical documents (i.e. clinic notes, history/progress notes, medication history, growth charts-height and weight, head circumference, labs, diagnostic reports, insurance authorization, and copy of the insurance card)

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 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: __/__/____