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 Weight Clinic/Adolescent Bariatric Surgery & Pediatric Weight Control Program

** 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

Pediatric Weight Clinic

☐ **Pediatric Weight Clinic**
- Multidisciplinary consultation
- Individualized medical and nutritional treatment
- Calculated BMI must be > 99% or > 95% with comorbidities
- **Needs a REFERRAL from Primary Care Provider**

☐ **Adolescent Bariatric Surgery Program**
- Multidisciplinary evaluation
- Individualized medical/surgical and nutritional treatment
- BMI must be > 40, or ≥ 35 with serious comorbidities
- **Needs a REFERRAL from Primary Care Provider**

Reason for visit: ◯ New Patient Consultation ◯ 2nd Opinion ◯ Transfer of Care ◯ Procedure/Surgery

Referral Diagnosis (Required): ______

Letter Number Letter or Number

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

Weight Control Family Group Program

☐ **Stanford Children's Health Pediatric Weight Control Program (Family-based Group Program)**
- **NO REFERRAL NEEDED. Patient/parent can call directly to enroll (650) 725-4425**
- Weight loss management (BMI must be > 95% or > 85% with a comorbidity)
- 6 month weekly family group sessions promoting lifestyle/behavior changes
- Children 8–12, Adolescents 13–15 (Groups in English and Spanish)

Provide patient contact and BMI information required below

Recent Height: ______ cm/in Weight: ______ lbs/kg Date of measurements: ___/___/______

BMI = ______ BMI percentile = ______

Current medical and psychiatric conditions: ☐ Diabetes ☐ Obstructive sleep apnea ☐ Hyperinsulinemia ☐ Hyperlipidemia ☐ NASH ☐ Hypertension ☐ Thyroid Problems ☐ Pseudotumor Cerebri ☐ Depression ☐ Developmental Delay ☐ PCOS

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)

Comments: ______

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: ___/___/______