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 Sleep Center

** 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

____________ ____________ __ __ / __ __ / __ __ __ __
REFERRING PROVIDER SIGNATURE (**REQUIRED**) FORM COMPLETED BY DATE

Type of Service Requested (all procedures done per LPCH Sleep Center protocol)

	6 Years or Older	Under 6 Years	Additional
☐ Polysomnogram Diagnostic Baseline	95810-26	95782-26	
☐ Polysomnogram + CPAP/BiLevel	95811-26	95783-26	
☐ Polysomnogram + Oxygen Titration	95810-26	95782-26	
☐ Polysomnogram + pH/Impedance Probe Study	95810-26	95782-26	pH probe 991034
☐ Mask Fitting and CPAP Acclimation (PAP-NAP)	95811-26	95783-26	
☐ Polysomnogram diagnostic with seizure montage	95810-26	95782-26	
☐ Ventilator/NIPPV Titration *(ordered only by Pulmonary MD)*			

Current Settings (Ventilator/CPAP/Bi-level)/Comments: ____________

LPCH Pulmonary/Sleep Physician Consultation

☐ Consultation with LPCH Pulmonary/Sleep Physician
Please Check One
☐ Before Polysomnogram
☐ After Polysomnogram
☐ Consultation Only

Note: Physician Consultations are scheduled through the LPCH Pulmonary Clinic. Consultations requested before Polysomnogram may delay study.

Reason for study: (REQUIRED)

☐ ADHD (F909)
☐ ALTE (R6813)
☐ Asthma (J45909)
☐ BPD (P271)
☐ Craniofacial Disorder (Q75.9)
☐ Cystic Fibrosis (E840)
☐ Daytime Hypersomnolence (G4710)
☐ Decannulation (J39.8)
☐ Down Syndrome (Q909)
☐ Enuresis (N3944)
☐ Myelomeningocele (Q059)
☐ Narcolepsy (G47419)
☐ Nocturnal Arousals (F518)
☐ Obesity (E668)
☐ Observed Apnea (G4733)
☐ Prader-Willi Syndrome (Q871)
☐ Pulmonary Hypertension (I272)
☐ Snoring (R0683)
☐ Other: ____________

Please fax all relevant clinical documents (i.e. history, progress notes, diagnostic sleep studies, etc).

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: ____________ Alternate Phone: ____________
HOME/CELL/WORK 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 ____________ Guarantor Relationship: ____________
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) Guarantor DOB: __ __ / __ __ / __ __ __ __

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

Authorization Expiration Date: __ __ / __ __ / __ __ __ __