STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center

REFERRAL REQUEST FORM

• STANFORD CENTER FOR ADVANCED LUNG DISEASE •

Phone: 650.736.5400 Fax: 650.723.3106

From: _ MD

Phone: ( ) _____

Fax: ( ) .

Address: ______

City: __

Zip: ___

Specialty: _____

Primary Care Physician: .

Phone: ( ) _____ Fax: ( ) _

Email: _

REQUIRED PATIENT INFORMATION:

Last Name: ___ First Name: ______ MI: __

DOB: _ Gender: ☐ M ☐ F

Home: ( ) ___ Cell: ( ) __

Patient's Address: _____

City: ___ State: ____ Zip: _____

Needs Interpreter? ☐ Yes ☐ No Language: _____

Diagnosis: _____

____

Service Requested/ Specialty Requested: ☐ Lung Transplant ☐ Other: _

Physician Requested: __

Type of Service: ☐ Consultation ☐ Treatment ☐ Other: _____

REASON FOR REFERRAL: Please attach current medical documentation (i.e. recent labs, diagnostic imaging, clinic notes), demographics sheet, and insurance information. Thank You!

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