Stanford Pain Management Center

CONSULTATION REQUEST FORM

Date: _____

Stanford Pain Management Center
Phone: 650-723-6238
Fax: 650-320-9443

# of pages faxed

Referring Provider Information:
Referred by (MD): Medical Group:
Phone: Fax: PCP:
Address: City: Zip:
This form completed by: Phone:
Patient Information (Please provide a copy of patient demographics/fact sheet):
Last Name: First Name: MI:
DOB: Gender: Male / Female Phone:
Patient's Address:
City/State/Zip: Need Interpreter? Y / N Language:
Reason for Referral:
Diagnosis/ICD-9:
Service/Specialty Requested: Physician Requested:
Type of Service Requested: ☐Consultation ☐2nd Opinion ☐Radiology Services ☐Lab Services ☐Follow up ☐Surgery ☐Other (please specify):
Reason for Referral:
Documentation Required (please fax with this form):
❖ Recent/relevant clinical notes/test results, i.e. History & Physical, MRI/CT/X-Ray results
❖ Proof of Insurance
❖ Authorization information (if required)