Referral Request Form

Lucile Packard Children's Hospital AT STANFORD

ATTN: REFERRAL CENTER
FAX: (650) 721-2884
PHONE: (800) 995-5724
E-MAIL: referral@lpch.org

Pediatric Weight Clinic/Adolescent Bariatric Surgery Pediatric Weight Control Program

**Please note, you can also register for LPCH MD Portal (https://mdportal.lpch.org) to submit referrals and track appointments online)*

Referrer Information:

Referring MD/NP/PA: _____ _____ _____ _____
Last Name | First Name | Phone# | Fax#

Please indicate your relationship to the patient: ☐ PCP ☐Other: _____
Specialty

PCP (if different from above): _____ _____ _____
Last Name | First Name | Phone#

_____ _____ _____
Referring Provider Signature | Form Completed by (please print) | Date

Reason for Referral: Check all that apply

❒ **Routine** ❒ **Medically Urgent – call Referral Center to expedite: 1-800-995-5724**

Pediatric Weight Clinic

❒ **Pediatric Weight Clinic (Individualized)**

- 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**

Family Group Program

❒ **Packard 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 co-morbidity)
- 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
☐ **Other**:_____

Please fax all relevant clinical documents including progress notes, growth charts, and labs.
Comments:
_____

Required Patient Information:

❒ Female ❒ Male Interpreter Required? ❒ Yes ❒ No _____ _____
Patient Language | Parent/Guardian Language

_____ _____ _____ _____ _____ _____
Last Name | First Name | MI | DOB | AGE

Patients Address: _____ City/State/Zip: _____

Primary Phone: _____ Alternate Phone: _____
Home/Cell/Work | Home/Cell/Work

Guardian Name: _____ Guardian Relationship _____

(For Internal Use) Insurance Plan: _____ Medical Group: _____
Insurance Phone: _____ Insurance ID #_____
Authorization Required? ☐ Yes # Visits Authorized: _____ Auth #_____
Auth Expiration Date: _____ *Please Remember to Fax Authorization*

REV 4/19/13