Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Referral Request Form

Attn: Referral Center
Tel: (800) 995-5724 Fax: (650) 721-2884

Motion and Gait Analysis Laboratory

** 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)

Reason for Referral

**Please note: A referral is not required for follow up patients with the same diagnosis if they have been seen in the last 3 years. Please contact the clinic directly to schedule a follow up appointment at (650) 723-5308.*

Reason for Referral: ☐ Lower Extremity Gait Test ☐ Upper Extremity Gait Test

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

Reason for Referral: _____

_____

Specific Problems: _____

Treatment Considerations: _____

If URGENT please provide reason: _____

Please remember to fax authorization.

Gait Analysis CPT codes to check for Prior Auth - 96000, 96001, 96002, 96003, 96004, 95831, 95851, 92548

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: ___/___/_____