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

# Referral Request Form

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

# Cardiovascular Connective Tissue Disorders Clinic Referral Form

** 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

**If you would like an MD Consult regarding this referral please call the Referral Center at (800) 995-5724.**

Reason for visit: ◯ New Patient Consultation ◯ 2nd Opinion ◯ Transfer of Care ◯ Procedure/Surgery (no consultation needed)

**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.* Service/ Specialty Requested: CARDIOLOGY/CCTD CLINIC Provider Requested: Dr. Ronnie Thomas Collins

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

Reason for Referral: _____

**Please fax all relevant clinical documents and please fax authorization for the following CPT codes:**

**Cardiology, Dentist, Endocrinology, Geneticist, Genetic Counselor, Nephrology, Neuropsychology, Neurology, Opthalmology, Orthopedics, Psychiatry,**
**New: 99201-99205. Established: 99211-99215**
**Nutrition**
**New: 97802. Established: 97803 - CCS patients: Z4308**
**Neuropsychology Testing: 96118**

## 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: ___/___/_____