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

Referral Request Form

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

Occupational Therapy Services

** You can register for Stanford Children's Health MD Portal (https://mdportal.stanfordchildrens.org) to submit referrals and track appointments online.*

◯ **Medically URGENT/PRIORITY**

◯ Routine

Referring Provider

Referring MD/NP/PA: _____ (LAST NAME) _____ (FIRST NAME) ext _____ (TELEPHONE) _____ (FAX)

Please indicate your relationship to the patient: ◯ PCP ◯ Other (Specialty): _____

_____ (REFERRING PROVIDER SIGNATURE (**REQUIRED**)) _____ (DATE (**REQUIRED**)) _____ (TIME (**REQUIRED**)) ◯ AM / ◯ PM

_____ (FORM COMPLETED BY)

Referring to Rehabilitation Services

In order to schedule a patient for Occupational Therapy, ***the insurance authorization*** (if required by insurance) ***must be in place*** for the required procedure CPT codes (see list).

PLEASE REMEMBER TO FAX AUTHORIZATION.

PLEASE FAX ALL RELEVANT CLINICAL DOCUMENTS
(i.e. clinic notes, history and progress notes, medical history, and a copy of the insurance card).

Reason for Referral

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

Referral Diagnosis (**Required**): _____

If URGENT please provide reason: _____

Comment/Precautions: _____

Please select type of evaluation:

Type of Evaluation (check all applicable)	CPT Codes	X Codes
Occupational Therapy Evaluation & Treatment—		
☐ Feeding &/or Swallowing	92610	x4100, x4102
☐ Biofeedback	97165, 97166, 97167	x4100, x4102
☐ Sensory Motor Program	97165, 97166, 97167	x4100, x4102
☐ Upper Extremity/Hand Therapy	97165, 97166, 97167	x4100, x4102
☐ General	97165, 97166, 97167	x4100, x4102

Required Patient Information

◯ Female ◯ Male ◯ Other 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 (circle/click)) Alternate Phone: _____ (HOME | CELL | WORK (circle/click))

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: _____