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

Referral Request Form

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

Comprehensive Single Ventricle Program 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 ◯ Follow Up Evaluation

Please contact the clinic directly to schedule a follow up appointment.

Service/Specialty Requested: SVP CLINIC Provider Requested: Dr. Sharon Chen

ICD10 (**Required**): (Letter Number | Letter or Number) Q 2 0 . 4 _ _ _

Reason for Referral: _____

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

Nutrition:
For CCS patients: 5200000139 (Z4308)
For non-CCS patients:
-Initial visits: 5100000072 (97802)
-Return visits: 5100000073 (97803)

Neuropsychology:
Neuropsychological Testing: 96118 (probably primary)
Psychological Testing: 96101
Developmental Testing: 96111
Parent Conference: 90887 (for follow-up/result review)

Cardiology, Nephrology, Hepatology:
New E&M: 99201-99205
Established E&M: 99211-99215
Office consult codes: 99241-99245

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: ___/___/_____