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

International Patient Services
725 Welch Road
Palo Alto, CA 94304
Ph: 650-709-3546
Fax: 650-497-8355

International Pediatric Patient Information Form

Patient Name:

____
(Last) *(First)* *(Middle)*

Date of Birth: ____________________ Sex: M F U.S. Social Security # ________________
(if applicable)

Patient's Home Address:

____

____

Patient's Primary Language: Patient's Primary Caregiver:

______________________ ______________________

Parent Information:

Mother's Name: ____
(include mother's maiden name)

Date of Birth: ____________________ Primary Language *(if different from Patient's)*: ____________________

Telephone: ______________________________ Mobile: ______________________________
(include country code) *(include country code)*

Email:______________________________ Occupation: ____________________

Name of Employer: ____

Address:

____

____

Telephone: ______________________________ Fax: ______________________________
(include country code) *(if applicable)*

Father's Name: ____

Date of Birth: ____________________ Primary Language *(if different from Patient's)*: ____________________

Telephone: ______________________________ Mobile: ______________________________
(include country code) *(include country code)*

Email:______________________________ Occupation: ____________________

Name of Employer: ____

Address:

____

____

Telephone: ______________________________ Fax: ______________________________
(include country code) *(if applicable)*

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U.S. Contact *(if applicable)***:**

Contact Name: ______________________________ Relationship to Patient: ____________________

Address:

____

____

Telephone: ______________________________ Mobile: ______________________________

Do you consent for Stanford Children's Health to discuss patient's health information with this contact? Yes No *(circle one)*

Who referred you to Stanford Children's Health? *(please provide name, relationship, and contact information)*

____

Reason for Referral:

*** Please complete and return this form to InternationalPatientServices@stanfordchildrens.org and include the patient's written medical records (in English) and imaging studies from the past year. We will contact you within 24-48 hours of receiving your email. ***