



STANFORD

HOSPITAL & CLINICS

Stanford University Medical Center

REFERRAL REQUEST FORM

Thank you for choosing Stanford Hospital and Clinics. We look forward to partnering with you in your patient's care.

Date _____

Stanford Referral Center

Phone: (877) 254-3762

Physician Helpline: (866) 742-4811

Fax: (650) 320-9443

of pages faxed _____

Referring Provider Information:

Referred by (MD): _____ Medical Group: _____

Phone: _____ - _____ - _____ Fax: _____ - _____ - _____ PCP: _____

Address: _____ City: _____ Zip _____

This form completed By: _____ Phone: _____ - _____ - _____

Patient Information *(Please provide copy of patient demographics/face sheet):*

Last Name: _____ First Name _____ MI _____

DOB _____ Gender: Male/Female Phone: _____ - _____ - _____

Patient's Address: _____

City/State/Zip: _____ Needs Interpreter? Y / N Language: _____

Reason for Referral:

Diagnosis/ICD-9 _____

Service/Specialty Requested: _____ Physician Requested: _____

Type of Service Requested: Consultation 2nd Opinon Radiology Services Lab Services
 Follow up Surgery Other *(please specify):* _____

Reason for Referral: _____

Documentation Required *(please fax with this form):*

- ❖ Recent/relevant typed clinical notes/test results, i.e. History & Physical, MRI/CT/X-rays results
- ❖ Proof of Insurance
- ❖ Authorization information (if required)