Referral Request Form

ATTN: REFERRAL CENTER
FAX: (650) 721-2884
PHONE: (800) 995-5724
E-MAIL: referral@lpch.org

Please fill in all requested data below and print and FAX (or e-mail) with relevant clinical notes and a copy of the insurance card. You can also register for the LPCH MD Portal (https://mdportal.lpch.org) to complete online referrals and track appointments. If you mark as "Medically Urgent" below, please call the Referral Center at (800) 995-5724 immediately after faxing to (650) 721-2884. Thank you!

☐ **Routine** ☐ **Medically Urgent (**reason): _____

Referrer Information:

Referring MD: _____ (Last Name) _____ (First Name) _____ (Phone #) _____ (Fax #)

Specialty: _____ MD Signature: _____

PCP (if different from above): _____ (Last Name) _____ (First Name) _____ (Phone #)

Patient Information:

☐ Female ☐ Male Interpreter Required?: ☐ YES ☐ NO _____ (Guardian Language) _____ (Patient Language)

_____ (Last Name) _____ (First Name) _____ (MI) _____ (DOB)

Patient's Address: _____ City/State/Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Guardian Name : _____ Guardian Relationship : _____

Referral Diagnosis: _____ ICD-9: _____

Service Requested:

Reason for Referral: _____

_____

Service/Specialty Requested: _____ Physician Requested: _____

Type of Service Requested: ☐ Consultation ☐ Transfer of Care (assume evaluation and management of new patient)

Comments: _____

_____

Insurance Information:

Requires Authorization? ☐ YES ☐ NO Auth #: _____ # of Visits: _____ Auth Exp Date: _____

☐ PPO ☐ HMO ☐ Other Insurance Plan: _____

Insurance ID: _____ Medical Group: _____ Phone #: _____

Insurance Holder's DOB: ____ ____ ____ Relationship to Patient: _____ _____ (Name)

Form Completed by: _____ Phone Number: _____ Date: _____