Referral Request

Thank you for choosing Stanford Health Care.
We look forward to partnering with you in your patient's care.

STANFORD REFERRAL CENTER

Phone: 877-254-3762
Physician Helpline: 866-742-4811
Fax: 650-320-9443

Date: _____
pages: _____

☐ Routine
☐ Urgent

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: _____ Phone: _____ Gender: ☐ Male ☐ Female
Patient's Address: _____
City/State/Zip: _____
Needs interpreter? ☐ Yes ☐ No Language: _____

REASON FOR REFERRAL:

Diagnosis/ICD: _____
Service/Specialty Requested: _____
Physician Requested: _____

☐ **Contact referring provider if requested physician is unavailable**

Type of Service Requested: ☐ Consultation ☐ 2nd Opinion ☐ 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*)

Stanford HEALTH CARE
STANFORD MEDICINE