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In This Issue

Packard Children's Craniofacial and Plastic Surgeons Change Kids' Lives

TEAM PROVIDES EXPERT CARE FOR DEFORMITIES OF THE FACE, NECK AND SKULL

Deformities to children's faces and skulls are tricky to treat. Not only can they impinge on a variety of organs—such as skin, bone, brain and eyes—but aesthetic concerns play a significant role in treatment. Surgeons must consider potential facial scarring and plan how to accommodate growth of the child's features.

Packard Children's craniofacial and plastic surgery team is up to the challenge. The team's diverse group of clinicians and researchers provides innovative, multidisciplinary expertise on congenital defects, developmental problems and traumatic injuries affecting the head.

"In one day, we can have patients see all of the specialists in the craniofacial clinic," said H. Peter Lorenz, MD, director of craniofacial surgery and service chief for plastic surgery at Packard Children's. The clinic provides one-stop access to practitioners from craniofacial surgery, neurosurgery, otolaryngology, orthodontics, genetics, psychiatry, audiology, speech-language therapy, ophthalmology, nursing and social work. "Families like that—it's a long half-day for them, but they don't have to make a lot of separate doctor trips," Lorenz said.

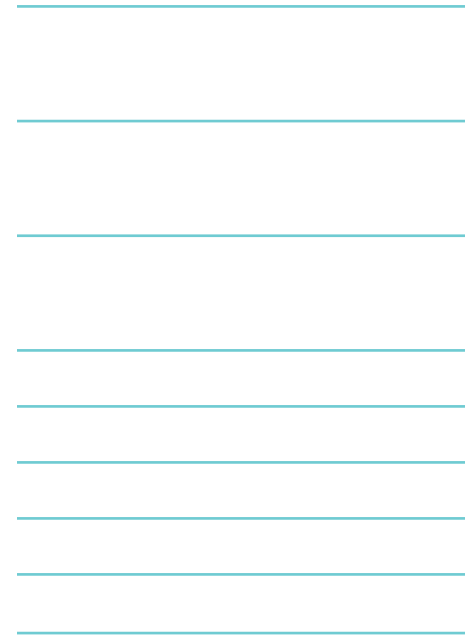
After clinic, the team writes a coordinated care plan for each child, ensuring that all treatments will be delivered at the right stage of development. The range of patients' needs is as varied as the clinicians



Before (top) and after: A new surgical device was used to repair this baby's abnormally small jaw without hindering its growth.

themselves. Children with congenital defects such as cleft palate or malformed facial or skull bones need medical attention in infancy; others start treatment later in childhood or adolescence.

"Any patient born with a clear deformity of the face should be referred to us right after birth," said craniofacial surgeon Rohit Khosla, MD.



Stretching the Bones

Cleft lip and palate, hemifacial microsomia—in which one side of the face is smaller than the other—and craniosynostosis, or prenatal fusion of the skull plates, can be most successfully repaired when treatment begins early.

"We can stretch bone to make it grow," Khosla explained.

Packard Children's research has produced pioneering advances in bone distraction, in which a surgeon cuts the bone in two and braces the two halves a few millimeters apart. The surgeon widens the gap a little each day until the bone is large enough, and the body fills the space with new bone.

The team uses distraction to treat undersized jaw bones, which cause a too-small mouth that crowds the tongue backward into the airway. Distraction is also appropriate for facial asymmetry caused by underdevelopment of one side of the face. After the two- to three-month procedure

ends, the enlarged bones grow at the same pace as other bones in the face, and many children need no further surgery.

Cleft lip and palate patients, on the other hand, typically require a series of surgeries. “As they grow, they need little alterations,” Khosla said. When a patient is 3 months of age, a surgeon performs the first operation to close the gap in the lip. The palate can be closed at about 9 months, and follow-up surgeries on the gum line and nose occur at age 7 and in the teen years, respectively. Some children need additional reconstruction to facilitate speech or enlarge the upper jaw.

Craniosynostosis treatment brings craniofacial and plastic surgeons together with the Packard Children's neurosurgery team to correct prenatal fusion of the skull bones, a defect that restricts brain growth. The team opens the seams in the skull so that the brain will have room to develop, and the infant's body grows new bone to fill the gap. “That ability is lost by age 2,” Lorenz said, “so we have a window when we can do these operations.”

Giving Smiles Back to Kids

Many patients come to Packard Children's for evaluation and repair of soft-tissue defects of the face, head and neck. The Packard team offers facial reconstruction for trauma patients, reanimation surgery for kids who lack nerves and muscles used to smile, and treatment of varied skin, vascular and cosmetic problems.

“We're working with children to really change their lives,” said Khosla. “That's the most rewarding part of what I do.”

Khosla and James Chang, MD, who chairs the division of plastic surgery at Stanford Hospital & Clinics, restore smiles to children who lack facial nerve and muscle function. By transplanting a small muscle from the thigh to the face, they give back a child's ability to show facial expressions. Similarly, during microsurgery for traumatic wounds, they transplant tissue from other parts of the body to the wounded area and meticulously connect blood vessels and nerves so that the transplant can thrive.

Packard Children's plastic surgeons also have substantial expertise in managing vascular malformations such as hemangiomas. These nonmalignant blood vessel tumors cause red or purple blotches on the skin of about 12 percent of infants. Though

hemangiomas often shrink, they sometimes leave large scars behind. If patients are referred early, the team can help families decide whether surgery is necessary. Removing other skin malformations, including large nevi (moles), is also a routine part of the team's practice. They frequently implant balloon expanders under the skin to generate new tissue for repairs, minimizing later scarring.

A Scar-Free Future?

Lorenz hopes to one day do his job without leaving any scars at all. That's why his lab is studying how fetal skin repairs itself. The lab's 2008 discovery of Dot cells, key players in the fetal ability to heal without scarring, sparked excitement for the future of scarless surgery.

“Dot cells are like soldiers for stem cells,” Lorenz explained. Unlike stem cells, they don't become new tissue in a test tube; instead they home in on a wound and help manufacture healthy new skin. Fetal mice have lots of Dot cells, whereas juvenile and adult mice have only a few. The same pattern holds for humans.

Lorenz hopes to one day be able to infuse Dot cells into children having skin surgery to prevent scars from forming. His research has already shown that the strategy works in mice. “Dot cells know how to go to the wound site without any coaching,” he said. And the cells don't appear to trigger immune rejection when swapped between animals.

“In theory, our plan would be to culture Dot cells and have a supply available for use where you don't have to worry about the donor,” Lorenz said. “We could inject the cells into patients with skin problems to enable scarless skin repair. The possibilities are really exciting.”

For more information about Packard Children's Craniofacial Anomalies Clinic or the Plastic Surgery Clinic, visit craniofacial.lpch.org or plasticsurgery.lpch.org, or call (650) 497-8201. Contact Elena Hopkins, RN, MS, PNP, at (650) 497-8654 with any questions or referral issues.

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NIH Stimulus Funds Awarded to Packard Children's to Study Premies' Lung Disease

PHYSICIAN-IN-CHIEF HUGH O'BRODOVICH LEADS RESEARCH TEAM

A Packard Children's team has received a two-year, \$3.5 million award from the American Recovery and Reinvestment Act to study a lung disease that affects 15,000 premature U.S. infants each year.

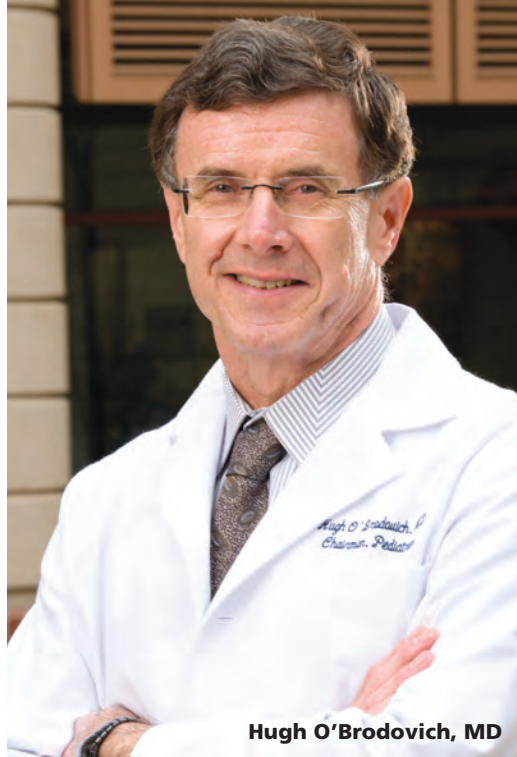
Preemies with bronchopulmonary dysplasia suffer abnormal development of the alveoli, the air sacs at the bottom of the lungs. They spend months in costly neonatal intensive care units and suffer permanent reductions in lung function. Yet even among extremely premature babies, the disease is not universal: About half of infants born at 28 to 29 weeks' gestation do not get BPD, for instance.

"It's always been a puzzle to physicians why there may be two very premature babies who look the same and are treated exactly the same, but one will develop BPD and one won't," said Packard Children's Physician-in-Chief Hugh O'Brodovich, MD, who is leading the research team. Prior studies have shown that supplemental oxygen use, ventilator support and lung infections predispose to the development of BPD, but no one knows why some infants get BPD yet others do not.

The Packard Children's team is taking a new approach. Their grant, the largest given to any group at Stanford University from federal stimulus funds, will enable a hunt to discover which genetic modifications contribute to the development of BPD. Two earlier studies in twins showed that BPD is highly heritable—50 to 80 percent of the risk can be explained by genetics. But no one knows which genes or what minor genetic variations, known as single nucleotide polymorphisms, contribute to the disease.

By combining statewide data on premature births from the California Perinatal Quality Care Collaborative with newborns' blood samples cataloged by the California Department of Public Health, the researchers will compare 1,000 preemies who developed BPD with 1,000 control preemies who did not develop BPD. They'll look for specific genes or gene pathways that differ between the two groups. The goal is to identify disease mechanisms to target in future treatments.

Not only would better treatments save infants from long,



Hugh O'Brodovich, MD

"It's always been a puzzle to physicians why there may be two very premature babies who look the same and are treated exactly the same, but one will develop bronchopulmonary dysplasia and one won't,"

costly hospital stays, but they would also prevent disability later in life. On average, BPD leaves babies with about 70 percent of normal lung function, which puts them at high risk for chronic obstructive pulmonary disease as their lungs age, O'Brodovich explained. "If you start with only 70 percent of normal lung function, with a normal rate of aging, you'll run out of lungs in your fifth or sixth decade," he said.

The project uniquely combines rich statewide data sources with the expertise of several prominent scientists at Packard Children's and Stanford University. In addition to O'Brodovich, a pediatric pulmonologist, the team includes neonatologists and CPQCC leaders Jeffrey Gould, MD, MPH, and David Stevenson, MD; neonatologist Richard Bland, MD; biostatistician Laura Lazzeroni, PhD; epidemiologist Gary Shaw, DrPH; and Mark Krasnow, MD, PhD, who chairs Stanford's Department of Biochemistry and is an internationally recognized expert in lung development.

"If we are able to identify genes or pathways that were not previously suspected to play roles in BPD, that will open whole new avenues of potential therapeutic intervention," O'Brodovich concluded.

Pediatric Hospitalists Play Essential Role for Packard Children's Inpatients

HOSPITALIST TEAM COORDINATES INPATIENT CARE, LEADS QUALITY IMPROVEMENT

Whether they have a simple problem or a complex illness, pediatric inpatients need attentive, well-planned care. At Packard Children's, this care often comes from physicians on the pediatric hospitalist team.

"We're the jacks-of-all-trades for our inpatients," said Joseph Kim, MD, director of the pediatric hospitalist program for Packard Children's and the Packard-affiliated Pediatric Unit at El Camino Hospital. During the day, hospitalists run the general pediatrics inpatient units and lead inpatient care, Kim said. "At night, we wear our fireman's hats and put out fires for clinical and nonclinical issues on several units, including specialty services such as liver transplant and stem cell transplant." The team also plays significant roles in educating resident physicians, answering Emergency Code and Rapid Response Team pages, and leading safety and quality improvement efforts.

Establishing good working relationships with patients, their families, and referring physicians is a key aspect of a hospitalist's job.

"We come up with a plan for each child that meets the family's and the child's needs," said hospitalist Lauren Destino, MD. "We also like talking to primary care providers—they've known the patient longer. They might be able to add not only to medical

information, but also give useful details about the whole family's situation."

All 15 of Packard's hospitalists are residency trained and board certified in general pediatrics, and individual physicians on the team have specialized expertise in pediatric palliative care, hematology/oncology and doctors' use of information technology. Subspecialist physicians, nurses, case managers, physical therapists, nutritionists and many other Packard Children's providers collaborate closely with the team each day.

To keep inpatient units running safely and efficiently, Packard's Children's hospitalists lead quality-improvement projects. For instance, they recently instituted discharge rounds held 48 hours before a patient is scheduled to go home. These rounds bring together all key caregivers to discuss discharge concerns with the patient and family, a measure that has improved discharge times. "This affects every acute care patient that goes through Packard, so it's a lot of hours saved over the course of a year," Kim said.

The team has also developed night safety rounds in which a hospitalist, the senior residents and a nursing supervisor see high-acuity patients in each of Packard's five acute care units at the beginning of the night. "We're asking what problems could arise and how to head them off," Kim said. "The project has really improved communication between nurses and physicians at nighttime."

When patients are ready to go home, the hospitalist team contacts referring physicians by phone or fax to update them on their patients' hospital stays.

"If there are any concerns from the referring doctor's end, we want to hear about it," Kim said. "We want to make that transition from hospital to home as smooth as possible."

Discharging healthy children who arrived at the hospital in bad shape is one of the best parts of Destino's job, she said. "It can be really rewarding to know that we've followed these patients through thick and thin, and they're better and ready to go home."

For more information about the hospitalist team, e-mail Joseph Kim at joekim@stanford.edu.





Packard Children's Develops New Treatments for Obstructive Sleep Apnea

KIDS' SNORING CAN WARN OF GAPS IN SLEEP BREATHING

Snoring is more than just a funny noise. For many children, that rumbling is a sign of obstructive sleep apnea, which occurs when extra tissue in the nose or throat blocks breathing and interrupts sleep.

"Sleep is when we regenerate our neurotransmitters and free up brain space to create new memories," said Peter Koltai, MD, the division chief of pediatric otolaryngology at Packard Children's. "Interruption of sleep interferes with a vital physiological function."

That's why Koltai's team of ear, nose and throat specialists is working to improve diagnosis and treatment for sleep apnea, which affects 1 to 2 percent of U.S. children. The disorder causes nighttime awakenings, restless sleeping and occasional bed-wetting, and daytime tiredness and problems paying attention.

To see if the airway is blocked, Koltai recommends that kids who snore have a full physical and an evaluation for enlarged tonsils and adenoids. As part of this evaluation, Packard Children's offers overnight sleep studies to identify gaps in breathing.

When the sleep study shows apnea, Koltai's team can surgically remove enlarged tonsils and adenoids, a procedure that has improved dramatically in recent years. One option is to use a microdebrider to reduce the size of the tonsils, leaving a small amount of tonsil tissue that protects the throat muscles from postsurgical bleeding and infection.

"Tonsils are like belly buttons—they come as innies and outies," Koltai said. "This operation is ideal for the 'outies' in young children who have no medical problems except mild sleep apnea and very loud snoring."

In some cases, tonsillectomy and adenoidectomy doesn't fix the problem. For the 15 to 20 percent of patients who keep

snoring, Packard's otolaryngologists use a flexible endoscope to see hard-to-examine parts of the nose and throat, a technique Koltai developed.

Thanks to flexible endoscopy, he was the first to show that some older children have noisy breathing due to laryngomalacia—a loosening of tissue in the voice box previously thought to be confined to infants. Koltai's team repairs this defect with laser surgery. Other kids have poor throat muscle tone, which can be treated with continuous positive airway pressure (CPAP) ventilation at night; the ventilator blows air into the back of the throat to hold it open. And some children have enlarge-



Peter Koltai, MD

ment of the lingual tonsils, an often-ignored set of tonsils located "at the funky part of your tongue way in the back," Koltai said.

To handle enlarged lingual tonsils, Koltai's team developed a new surgery that improves on old methods for removing the extra tissue. Older approaches faltered because the lingual tonsils are hard to see and tend to bleed heavily. The new operation uses an endoscope to visualize the lingual tonsils, and a surgical technique called Coblation to "melt" the excess tissue away. The surgeon passes a small radiofrequency current through the tissue, vaporizing cells at low heat. Kids have little bleeding, experience minimal pain and recover quickly—they're usually eating a normal diet 24 hours later.

"We're really committed to improving treatments for this disease that has a substantial impact on the lives of so many children," Koltai concluded.

For more information about the ENT team or services at Packard Children's, visit ent.lpch.org or call (650) 497-8841. To learn more about Respiratory Specialties at Packard Children's, visit respiratory.lpch.org.

ED Team Tests Drive-Through Clinic Model

Cars can be effective examination rooms, preventing the spread of infectious disease between patients and from patient to caregiver. That's the finding of a Stanford Hospital & Clinics study of a drive-through emergency room published online Jan. 13 in the *Annals of Emergency Medicine*. The hospital's emergency medicine team, which serves both pediatric and adult patients, tested whether a drive-through influenza clinic could help with increased emergency department visits that were anticipated because of the H1N1 pandemic. Their simulation, in which Red Cross volunteers played the parts of patients, showed that patients received appropriate diagnoses and treatment decisions. Drive-through care kept the patients separated from each other and cut treatment time from an average of 90 minutes in the emergency department to 26 minutes in the parkade. The researchers, led by Eric A. Weiss, MD, an associate professor of emergency medicine at the Stanford University School of Medicine, have now developed a general drive-through plan to assist all the hospitals in Santa Clara County with setting up drive-through triage at their own facilities. "A drive-through medical clinic is not only a feasible model, but may be a preferred type of alternative care center," said Weiss.

Physician Partner Relations Update

MD Portal Enhancement

The MD Portal Web team continues to enhance your online tool for referring, tracking and viewing patient records online.

All nonurgent referrals can be submitted online via the MD Portal.

Submitting referrals online allows you to track the status of the referral and see when your patient gets scheduled.

A recent change was made to the online referral form to provide a more visible reminder to please call the Referral Center directly at (800) 995-5724 for all urgent or stat referrals.

If you are interested in signing up for the MD Portal, please go to mdportal.lpch.org.

Alternatively, you can contact Marta Miller at (650) 724-9606.

Upcoming Physician Engagement Event

The next Physician Engagement Reception will be held March 18 at the Stanford Park Hotel from 5:30 to 8 pm. These events are designed to provide community and referring physicians with an ongoing forum for engaging with Packard Children's, receiving updates on the hospital's priorities and giving feedback to our Physician Partner Relations Committee. Requests for invitations should be emailed to Fouzel Abbas at fabbas@lpch.org.

After Hours Clinic Updates

We would like to thank you for referring your patients to Packard Children's After Hours Clinic. At the end of 2009, the Physician Partner Relations department conducted a survey to solicit your opinions regarding your referral experience as it relates to the clinic and the services provided by Rainbow Call Center. We had a great **73 percent response rate** and are now assessing your feedback to determine how best to provide you with improved service in 2010.

Winter hours for the After Hours Clinic remain in effect through March 2010:

- » Monday to Friday: 6–9 pm
- » Saturdays: 1–5 pm
- » Sundays: 9 am–5 pm

Publications

■ Preferential Lower Respiratory Tract Infection in Swine-Origin 2009 A(H1N1) Influenza. Yeh, Luo, Dyner, Hong, Banaei, Baron, Pinsky. *Clinical Infectious Diseases*. 2010 Jan 4. [Epub ahead of print]

■ A comparison of laparoscopic and robotic assisted suturing performance by experts and novices. Chandra, Nehra, Parent, Woo, Reyes, Hernandez-Boussard, Dutta. *Surgery*. 2009 Dec 30. [Epub ahead of print]

■ Aluminum Content of Parenteral Nutrition in Neonates: Measured Versus Calculated Levels. Poole, Schiff, Hintz, Wong, Mackenzie, Kerner. *Journal of Pediatric Gastroenterology and Nutrition*. 2009 Dec 22. [Epub ahead of print]

■ Predicting time to hospital discharge for extremely preterm infants. Hintz, Bann, Ambalavanan, Cotten, Das, Higgins; Eunice Kennedy Shriver National Institute of Child Health and Human Development Neonatal Research Network. *Pediatrics*. 2010 Jan;125(1):e146–54.

■ IUDs and Adolescents—An Under-Utilized Opportunity for Pregnancy Prevention. Yen, Saah, Adams, Hillard. *Journal of Pediatric and Adolescent Gynecology*. 2009 Nov 4. [Epub ahead of print]

■ Confronting social disparities in child health: a critical appraisal of life-course science and research. Wise. *Pediatrics*. 2009 Nov;124 Suppl 3:S203–11.

■ Vein of Galen malformation. Hoang, Choudhri, Edwards, Guzman. *Neurosurgical Focus*. 2009 Nov;27(5):E8.

■ Cyclophilin C-associated protein/Mac-2 binding protein colocalizes with calnexin and regulates the expression of tissue transglutaminase. Kong, Lin, Li, Longaker, Lorenz. *Journal of Cellular Physiology*. 2010 Jan 4. [Epub ahead of print]

■ Long-term terbutaline exposure stimulates alpha-1-Na+-K+-ATPase expression at posttranscriptional level in rat fetal distal lung epithelial cells. Rahman, Gandhi, Otulakowski, Duan, Sarangapani, O'Brodovich. *American Journal of Physiology: Lung, Cellular and Molecular Physiology*. 2010 Jan;298(1):L96-L104.

■ Metalloporphyrins in the management of neonatal hyperbilirubinemia. Stevenson, Wong. *Seminars in Fetal & Neonatal Medicine*. 2009 Dec 16. [Epub ahead of print]

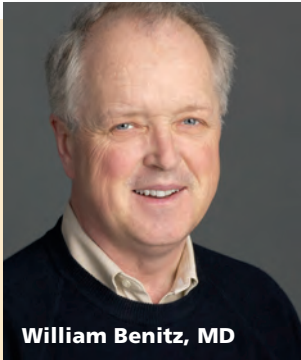
■ Factors influencing breast milk versus formula feeding at discharge for very low birth weight infants in California. Lee, Gould. *The Journal of Pediatrics*. 2009 Nov;155(5):657–62.

■ Choanal atresia: current concepts and controversies. Corrales, Koltai. *Current Opinion in Otolaryngology & Head and Neck Surgery*. 2009 Dec;17(6):466–70.





Faculty Update

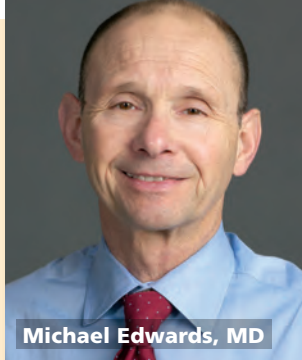


William Benitz, MD

After a national search, **WILLIAM BENITZ, MD**, the Philip Sunshine, MD, Endowed Professor in Neonatology, has been named as the division chief of neonatology at Packard Children's. Benitz has been acting head of the division since 2007. His new appointment took effect Dec. 1. Benitz completed his MD and postgraduate training at Stanford University, and joined the faculty in 1985. He has written more than 60 peer-reviewed publications and 22 book chapters and has co-edited six books.

CHRISTOPHER DAWES, president and CEO of Packard Children's, was recently elected chairman of the Board of Trustees for the National Association of Children's Hospitals and Related Institutions (NACHRI) and the National Association of Children's Hospitals (NACH). Dawes, whose two-year term began in October, assumed leadership in the midst of the national health-care debate that marks a significant juncture for those working to improve children's health. Dawes has been with Packard Children's since it opened, and has served as president and CEO since 1999.

MICHAEL EDWARDS, MD, director of pediatric

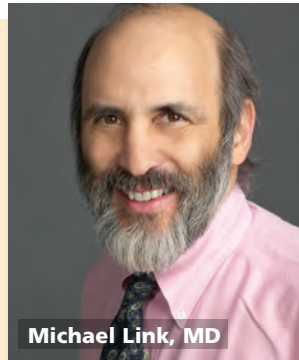


Michael Edwards, MD

neurosurgery, and **PAUL FISHER, MD**, service chief of pediatric neurology, received a \$1.6 million grant from the National Institutes of Health to treat children with diffuse pontine glioma, a rare, aggressive pediatric brain tumor. The treatment being tested targets EGFR VIII, a cell marker expressed on tumor cells but not in healthy brain tissue. Packard Children's Brain and Behavior Center is also funding the project.

The **STANFORD EMERGENCY DEPARTMENT** received the 2009 Malinda S. Mitchell Award for Service Quality at the annual Stanford Hospital & Clinics Employee Service Awards Banquet in October. The staff of the Stanford-LPCH Pediatric Emergency Department contributed significantly to the project, as reflected by recent large improvements in Press Ganey reports of overall patient satisfaction scores. In addition, despite a 30 percent increase in patient visits in the past five years, the pediatric emergency department team has cut the median wait time to see a physician to less than 30 minutes.

MICHAEL LINK, MD, has been elected president of the American Society of Clinical Oncology. While



Michael Link, MD

continuing his appointments at Packard Children's and Stanford University School of Medicine, Link will take office as president-elect at ASCO's annual meeting in June 2010, and will lead the prestigious organization of oncology practitioners for a one-year term from June 2011 to June 2012. As president, Link will lead the Society's efforts to advance cancer research and improve health policy for oncology patients.

The **DIVISION OF PEDIATRIC ANESTHESIA** has added several physicians to its staff in the last year:

ECHO ROWE, MD, graduated from the University of Washington School of Medicine in 2001. She then completed residencies in pediatrics at the University of California, San Diego and Rady Children's Hospital, and in anesthesia at Stanford Hospital. She has volunteered on pediatric medical teams in Guatemala, Mexico, Bangladesh and El Salvador.

GENEVIEVE D'SOUZA, MD, attended medical school at the University of Bombay in India, graduating in 1999. She held fellowships in pediatric pain management at Packard Children's and in pediatric anesthesia at the



Genevieve D'Souza, MD

A.I. duPont Hospital for Children in Wilmington, Del. She completed a residency in anesthesiology at Thomas Jefferson University in Philadelphia.

SAMUEL MIRELES, MD, an alumnus of Stanford University, earned his MD from the University of California, San Francisco in 2001. He recently held a fellowship in pediatric anesthesia at Packard Children's. He received residency training in anesthesia at Stanford Hospital and in pediatrics at Children's Hospital Oakland. Mireles was awarded the 2008 Anesthesia Department Research Award from the Stanford University School of Medicine.

MIRJANA VUSTAR, MD, attended medical school at the University of Novi Sad in the former Yugoslavia. She received residency training in anesthesiology at the Medical College of Georgia and completed a fellowship in pediatric anesthesia at the Children's Hospital of Philadelphia in 2000. Vustar was a member of the faculties of Vanderbilt University and the University of Texas Southwestern at Dallas before joining the Packard Children's team.



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Physician Update is published quarterly as part of an ongoing effort to serve the needs of physicians who refer to Lucile Packard Children's Hospital at Stanford. To share comments or secure more information, contact:

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Pediatric Infectious Diseases – Clinical Challenges in Primary Care

July 15, 2010

18th Annual Pediatric Update

July 16-17, 2010

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For complete conference info or to register, visit <http://cme.lpch.org>.