

**Referral Request Form
Mary L. Johnson Development and Behavior Unit**

**Attn: Referral Center
FAX: (650) 721-2884
Phone: (800) 995-5724**

Please type in all requested data below and FAX with relevant clinical notes and a copy of the insurance card.
For URGENT requests, please call the Referral Center immediately after submitting the form.
You can also register for the LPCH MD Portal (<https://mdportal.lpch.org>) to complete online referrals and track appointments.

Name of doctor referring: _____ MD Phone: () _____
Fax: () _____

Please indicate your relationship to the patient: PCP Other _____

REQUIRED PATIENT INFORMATION:

Female Male Interpreter Required? Y N Language: _____

_____ Last Name _____ First Name _____ MI _____ DOB / AGE

Parent's/Guardian's Name: _____ Home# _____ - _____ Cell # _____ - _____
Work # () _____ - _____

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

If Premie –
Gestational age at birth: _____ NICU born at: _____ BWT: _____

If not HRIF – Reason for Referral (What is the consult question?)

Discussed documentation for pediatrician requesting consultation: Y N

Authorization required? Y N # Visits Authorized: _____ Auth # _____

Expiration Date of Authorization: _____ Insurance Policy# _____

Insurance Plan: _____ Medical Group: _____ Phone: () _____
PPO HMO EPO POS:

Employer: _____ Address: _____

Form Completed by: _____ Phone: () _____

Date form completed _____ Rev: 06-12-09