STANFORD UNIVERSITY MEDICAL CENTER
Stanford Hospital and Clinics
Lucile Packard Children's Hospital

Lucile Packard Children's Hospital AT STANFORD

Referral Request Form
Pediatric Sleep Clinic

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

Please type in all requested data below and email (or print 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.

From: ___________________________________MD/NP/PA Phone: ( ) _________________________
Fax: ( ) _________________________
Please indicate your relationship to the patient: ☐ PCP ☐Other_______________________

Address: ______________________________________ City/State/Zip:____________________________

REQUIRED *PATIENT* INFORMATION:
❒ Female ❒ Male ________________ Interpreter Required? Y❒ N❒ Language:______________

_____________________________ ___________________________ ________ ________
Last Name First Name MI DOB

Parent's/Guardian's Name: _______________________ Home# _______-_____ Cell #________-_________
Work # ( )_________-__________

Patient's Address: ________________________________ City/State/Zip:____________________________

Recent Height: _______cm Weight: ________kg
Allergies:____
Medication/Dosage:______________________________________

Reason for study: ☐Asthma (493.90), ☐BPD (770.7), ☐Cystic Fibrosis (277.02), ☐Daytime hypersomnolence (780.54) ☐Enuresis (788.36) ☐Frequent nocturnal arousals (780.56) ☐Hyperactivity (314.04) ☐Neuromuscular disease (780.79) ☐Obesity (278.00) ☐Observed Apnea (327.23) ☐Snoring (786.09)
Other medical condition (CPT code) ____

Type of Service Requested: ❒ Polysomnogram diagnostic baseline (95810-26)
____
Need STAT appointment: Y❒ N❒ Follow up consultation with LPCH Sleep/Pulmonary MD: Y❒ N❒
____________________ ____
____

Authorization required? ❒ yes ❒ no # **Visits Authorized:** _________ **Auth #**____________________

Expiration Date of Authorization: ______________________ Insurance ID #_____________________

Insurance Plan: _______________Medical Group:______________________ Phone: ( ) ______________

Form Completed by: ___________________________ Phone: ( ) _____________Date:__________________

Rev: 8-6-09