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

Lucile Packard Children's Hospital AT STANFORD

Referral Request Form
Pediatric Weight Clinic

ATTN: REFERRAL CENTER
FAX: (650) 721-2884
PHONE: (800) 995-5724

Referral Date: ____________________
LPCH MR #______________________

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

Address: _______________________________________ City/State/Zip:_____________________________

REQUIRED PATIENT INFORMATION:
We need all of the information below filled out completely. This will be sent back to you if not filled out correctly.
Recent Height: _______cm/in Weight: ________lbs/kg BMI: _______
Is BMI > 95%? Y❒ N❒ (BMI must be > 95% to qualify for Pediatric Weight Clinic)

_____________________________ ___________________________ ________ ________ _____
Last Name First Name MI DOB AGE

Parent's/Guardian's Name: ________________________ Phone: C ( ) _______-_______W ( )_____-_____
Patient's Cell #________-_________ Home # ( )_________-__________

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

Spanish Speaking Y❒ N❒: Parent's Email:________________@____________.________

Diagnosis: ____ ICD-9: ____________________

Reason for Referral: ☐Obesity ☐Weight Loss Management ☐Bariatric Surgery Evaluation

Additional Information: ____

Type of Service Requested: ❒ Consult and recommend management ❒ Follow up ❒ Consult and treat
❒ Bariatric Surgery Evaluation ❒ Other:_____________________

Comments: ❒Family notified of Pediatric Weight Clinic consult.
____

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

Expiration Date of Authorization: _______________________ Insurance ID #______________________

Insurance Plan: ________________Medical Group:_______________________ Phone: ( ) ______________

Form Completed by: ____ Phone: ( ) ____________________
Rev: 5/8/07