

Date _____

of pages faxed _____

REFERRAL REQUEST FORM

STANFORD HOSPITAL & CLINICS

Interventional Radiology

Phone: (650) 736-9081 Fax: (650) 736-7734

From: _____ MD Phone: () _____

Address: _____ City: _____ Fax: () _____

Specialty: _____ PCP: _____

Phone: () _____ Fax: () _____

*Required Patient Information:

*Last Name: _____ *First Name _____ MI _____

*DOB _____ * Gender: M F *Patient's Phone: () _____

*Patient's Address: _____

*City/State/Zip: _____ *Needs Interpreter? Y N Language: _____

*Diagnosis: _____ *ICD-9: _____

*Service/Specialty Requested: _____ Physician Requested: _____

*Type of Service Requested: Consultation 2nd Opinion Treatment Lab Services Other
 Follow up Surgery (Outpt.) Surgery (Inpt.) Radiology Procedure

Reason for Referral: *Please attach supporting medical records and proof of insurance. Note: We cannot accept a single-page referral.*

Requires authorization? Yes No # of Visits Authorized: _____ Auth # _____
Expiration Date of Authorization: _____

Insurance Plan: _____ Medical Group _____ Phone: () _____

Form Completed By: _____ Phone: () _____