STANFORD
HOSPITAL & CLINICS
Stanford University Medical Center
STANFORD FIBROID CENTER

Date: _____

No of pages faxed: _____

REFERRAL REQUEST FORM

STANFORD HOSPITAL & CLINICS

Stanford Fibroid Center

Phone: (650) 498-1108 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: (   ) ____________________