Stanford HEALTH CARE

Need Assistance?
Physician Helpline: 866-742-4811

Referral Request Form

(Items with ** are required for processing)

Fax To: 650-320-9443 or Submit online using prism

Radiology Referrals / Orders: Use Form: https://stanfordhealthcare.org/imaging

Patient Information

Reason for Referral

If Medical Records Cover Sheet is included, Patient information can be left blank	Priority: Routine ☐ **Medically Urgent** ☐
Name *(First, Middle, Last)*** Sex: ☒ Male ☐ Female Test User	**If Medically Urgent**, please describe:
Date of Birth** 09/09/1999	Diagnosis/ICD 10** I11.0
Phone # ** (999) 999-9999 Secondary Contact #	Clinic / Specialty Requested** Open
Address** Test street	Physician Requested Location Requested
City** Palo Alto Zip Code** 76192 State CA	If Requested Physician is Unavailable, Can Patient be seen by another provider? ☒ Yes ☐ No ☐ Contact Referring Provider
Interpreter Needed? Yes ☐ No ☒ Preferred Language:	☒ Consultation ☐ 2nd Opinion ☐ Procedure ☐ Other

Referring Provider Information

Referring Provider Name** Tripty Gandhi		PCP Name
Practice Name** Private Practice		
Office Address** Santa Clara St		City** Santa Clara
State** CA	ZIP Code** 84297	NPI Number
Phone** (993) 939-1278	Fax** (993) 939-1278	Provider Specialty

Documentation Requested

☐ Relevant Clinical Notes **(History & Physical, Imaging and Lab results)**

☐ Copy of Insurance Card ☐ Insurance Authorization Information (If required)