

Motion Analysis & Sports Performance Laboratory

* You can register for Stanford Children's Health MD Portal (<https://mdportal.stanfordchildrens.org>) to submit referrals and track appointments online.

Medically URGENT/PRIORITY

Routine

Referring Provider

Referring MD/NP/PA: _____
LAST NAME FIRST NAME TELEPHONE ext FAX

Please indicate your relationship to the patient: PCP Other: _____
SPECIALTY

FORM COMPLETED BY _____

DATE _____

Reason for Referral

*Please note: For questions regarding referrals or scheduling, please call the lab directly at (408) 426-8124.

Reason for Referral: Running Analysis Post Surgical/Return-to-Sport Evaluation
 General Lower Extremity Evaluation Upper Extremity/Overhead Athlete Analysis

ICD10 (Required):

↓ Letter Number	↓ Letter Number	↓ Letter Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number	↓ Letter or Number

 (min 3 & max 7 characters)

Reason for Referral: _____

Specific Problems: _____

Treatment Considerations: _____

If URGENT please provide reason: _____

Please remember to fax authorization.

CPT codes to check for Prior Auth - 96000, 96004, 97161, 97162, 97163, and 97750

Required Patient Information

Female Male Stanford Children's Health Medical Record: _____ (IF AVAILABLE)

Interpreter required for either patient or parent/guardian? Yes No _____ PATIENT LANGUAGE _____ PARENT/GUARDIAN LANGUAGE

LAST NAME FIRST NAME MIDDLE NAME

Date of Birth: _____ Age: _____

Patient's Address: _____ City/State/Zip: _____

Patient's Phone: _____ Alternate Phone: _____
HOME | CELL | WORK (circle/click) HOME | CELL | WORK (circle/click)

Guardian Name: _____ Guardian Relationship: _____

Insurance Information

Self Pay **PLEASE INCLUDE A LEGIBLE COPY OF THE INSURANCE CARD (BOTH SIDES), AND AUTHORIZATION IF REQUIRED.**

Guarantor same as Subscriber? Yes No _____ Guarantor Relationship: _____
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT) Guarantor DOB: _____

Authorization Required: Yes No #Visits Authorized: _____ Auth#: _____

Authorization Expiration Date: _____