SANTA CLARA VALLEY HEALTH AND HOSPITAL SYSTEM

Consultation/ Referral Form

SCVHHS providers please fill shaded areas
Date: _____

Fax Information
# of Pages including form: _____
This fax is from: Ped Endocrine @ LPCH
Telephone: 650 723 5791

NAME
MR#
PCP

PATIENT

Last Name: _____ First Name: _____ MI: ____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Primary Language: _____ Translator Needed? ☐ Y ☐ N

REQUESTOR

Referring Provider: Pediatric Endocrinology Division @ LPCH Signature: D. Wilson

VMC Doctor #: N/A Department: Pediatrics

Referring Clinic/Agency:

Inpatient: ☐ Ward/Team _____ ☐ Emergency Department

Primary Care: ☐ Chaboya ☐ Children's Shelter ☐ East Valley ☐ Fair Oaks ☐ Moorpark ☐ Silver Creek ☐ South Valley ☐ VHC ☐ Other: _____

Urgent Care: ☐ East Valley ☐ Moorpark ☐ OPD ☐ VHC ☐ Other: _____

Other: _____

Phone: 650 723 5791 Fax: 650 725 8375 Pager: 650 497 8000

If external clinic or agency:
Address: 300 Pasteur Dr. G313 City: Stanford State: CA Zip Code: 94305-5208

REQUEST

Consultant Name: Dan Delgado/ Trish Barreto Consultant Specialty/Department: Pediatric Healthy Lifestyle Clinic

Please Check One: ☒ ROUTINE OR ☐ URGENT
(Urgent consultations should be requested by phone)

Insurance Plan: _____ # of visits requested: _____ CCS Referral Indicated? ☐ Y ☐ N

Working Dx Obesity ICD-9 code 278.00

Reason for Request, Diagnosis and Relevant Clinical Information (Attach any necessary reports, tests, etc.)

Obesity - would benefit from healthy lifestyle program

* BMI = (Site preferred:). *

Please see attached growth chart and last note.
Thanks!

☐ PROCEDURE ONLY:

DISPOSITION

FOR REFERRAL CENTER USE ONLY (CHECK WHEN COMPLETE)

GUIDELINES DATA
☐ Guidelines met
☐ Guidelines not met
☐ PCP Notified

AUTHORIZATION DATA
☐ Authorization Obtained
Reference #_____
Number of Visits:_____
☐ Authorization Denied
☐ PCP Notified of Denial

APPOINTMENT DATA
☐ Appointment Kept (see below)
☐ Appointment Not Kept
☐ Appointment Rescheduled
Appt Date:_____
Appt. Time:_____

SPECIAL DATA
☐ CCS Referral Sent

REPORT DATA
Date of Report :_____
Report Faxed by SS to:
☐ PCP
Date:_____
☐ Authorizing Agency
Date:_____

PLEASE FAX THIS FORM AND PROGRESS NOTE TO:
(408) 885-3535

8886-P

DISPOSITION - PERMANENT MEDICAL RECORD

SCVMC #6898-16