



- Routine
- Urgent (If medically urgent, please describe)

REFERRING PROVIDER INFORMATION:

Referred by (MD, DO, NP, PA): _____ Form completed by: _____
 Medical Group: _____ Email: _____
 Phone: _____ Fax: _____ NPI: _____
 Address: _____ City: _____ Zip: _____

PATIENT INFORMATION (Please provide a copy of patient demographics)

Last Name: _____ First Name: _____
 DOB: __/__/____ Phone: _____ Gender: M F Other (specify) _____
 City/ State/ Zip: _____
 Needs Interpreter? Y N Preferred Language: _____

Referral Information:

Referral Reason per MD: _____
 Diagnosis (ICD-10 Code): _____
 Specific Stanford Physician requested?: _____

***If requested Physician is unavailable, can Patient be seen by another provider?** Y N

Testing ONLY **Consultation ONLY** **Consultation AND Testing**

*****Stanford Health Care to provide Follow-up Care (as needed)?** Y N

Indication for Autonomic Referral (you may check multiple items)		
ONSET	MAIN PROBLEMS	UNDERLYING/COMBINED CONDITIONS
<input type="checkbox"/> Acute (within a month)	<input type="checkbox"/> Syncope/Near-syncope	<input type="checkbox"/> Diabetes/ Pre-diabetes
<input type="checkbox"/> Subacute (months)	<input type="checkbox"/> Orthostatic Hypotension	<input type="checkbox"/> Parkinson's Disease/Parkinsonism
<input type="checkbox"/> Chronic (years)	<input type="checkbox"/> Postural Tachycardia	<input type="checkbox"/> Peripheral Neuropathy
<input type="checkbox"/> Acute on Chronic	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Supine Hypertension
<input type="checkbox"/> Recurrent/Episodic		<input type="checkbox"/> Generalized Hypermobility Joints
<i>Frequency:</i>		<input type="checkbox"/> Other (please specify)

DOCUMENTATION REQUIRED Please fax with this form and page 2 (if testing required):	
Autonomic Function Test Order Form (page 2)	Copy of Insurance Card
Relevant Neurology/Cardiology Notes	Authorization Information (if required)
3-Day of Orthostatic Blood Pressure Log (page 3)	Relevant Diagnostic Notes and Tests: EMG/NCS, EEG, Skin Biopsy, Radiology Imaging, Labs
Results of Tilt-table test or Autonomic Function Test if previously done	

***Please complete page 1 & 2 (if testing required) and attach required documentations.** Incomplete form/s and lack of key information or delay in providing relevant medical records may result in delay or denial of referral.



Stanford Autonomic Disorders
213 Quarry Rd | Palo Alto, CA 94304
Phone: 650-723-6469 Fax: 650-320-9443

- Routine
 Urgent (If medically urgent, please describe)

****Only complete this page if Testing is requested.**

Patient Name: _____

Date of Birth: _____

Phone Number: _____

#1. Please choose one of three testing options below

___ Full Battery Testing – Tilt Table Testing, Heart Rate Variability with Deep Breathing, Valsalva Maneuver, includes QSART

___ Cardiovascular Testing – Tilt Table Testing, Heart Rate Variability with Deep Breathing, Valsalva Maneuver

___ Quantitative Sweat Test Only (QSART)

#2. Please send insurance pre-authorization for the test

Pre-authorizations Autonomic Test for CPT codes of 95921, 95922, 95923, 95924 and 93660 are required. At minimum, both 95923 and 95924 are required. Most insurance policies include R55 as covering diagnosis code. R55 includes syncope and collapse, pre-syncope, near-fainting, blackouts, etc.

MEDICARE does NOT require pre-authorization. A few insurances DO NOT approve 95923 and/or 95924. In such cases, we can do limited tests with 95924 only or 93660 only.

For more information about using appropriate CPT codes:

Please, refer to this link in page 6 and 7: [14autonomicmodel_tr.pdf \(aan.com\)](#)

#3. Our nurse coordinator will contact your patient before the test

Your patient might have to reduce or hold certain prescribed medications as these can affect test results for a few days. Please let us know if you have any concerns:

Name of Ordering Physician: _____

Signature of the physician: _____

Phone Number: _____

MedLink

Send and manage referrals online
medlink.stanfordhealthcare.org

AUTONOMIC FUNCTION TEST ORDER FORM

Stanford Autonomic Disorders
213 Quarry Rd | Palo Alto, CA 94304
Phone: 650-723-6469 Fax: 650-320-9443

ADDITIONAL INFORMATION ONLY

Thank you for choosing Stanford Autonomic Disorders Program. Our clinic team aspires to provide the best consultation service and meet your expectations. Please fill out referral and order form for your patient. Once we receive forms and relevant records, we will review your request and contact your patient to schedule an appointment. In addition to EPIC Care Everywhere, we request that those records still be sent with the original referral to expedite the process.

Lack of key information or delay in providing relevant medical records may result in denial of consultation. We will keep consult requests open for 14 days after asking for missing documents or additional information.

CONDITIONS WE TREAT/MANAGE	CONDITIONS WE DO NOT TREAT/MANAGE
<ul style="list-style-type: none"> ▪ Syncope ▪ Orthostatic dizziness / orthostatic intolerance ▪ Neurogenic orthostatic hypotension ▪ Neurogenic supine hypertension ▪ Small-fiber neuropathies ▪ Autonomic neuropathies ▪ Sweating disorders besides idiopathic focal hyperhidrosis ▪ Paraneoplastic autonomic syndromes ▪ Pure autonomic failure ▪ Multiple system atrophy ▪ Autonomic failure in Parkinson disease or Lewy body dementia ▪ Autoimmune autonomic ganglionopathy ▪ Baroreflex failure ▪ Amyloidosis with autonomic neuropathy ▪ POTS (postural orthostatic tachycardia syndrome) ▪ Horner syndrome 	<ul style="list-style-type: none"> ▪ NON-postural dizziness ▪ Tachycardia/palpitations, non-postural ▪ CFS (Chronic fatigue syndrome), CFIDS, SEID, CFS/ME ▪ Fatigue, unspecified ▪ Brain fog / difficulty concentrating or focus / Memory problems ▪ (Non-specific) "Autoimmune conditions" ▪ Arrhythmia ▪ Mast cell diseases including mast cell activation syndrome (MCAS) ▪ CRPS (Complex regional pain syndrome), Reflex sympathetic dystrophy ▪ For diagnosis of EDS (Ehlers Danlos Syndrome) ▪ (Isolated) Gastrointestinal conditions/symptoms ▪ (Isolated) Genitourinary/Bladder symptoms ▪ Headache ▪ Idiopathic focal hyperhidrosis (hands/feet/armpits) ▪ Lyme disease ▪ Pain control ▪ PANDAS (Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal infection) ▪ Post-concussion syndrome ▪ Resting hypotension ▪ Secondary hypertension other than supine hypertension and baroreflex failure ▪ Seizure (or to rule out seizure) ▪ (Isolated) Sleep problems
<p>The list above is for reference only and is not exclusive. Each referral request will be reviewed carefully on a case-by-case basis.</p>	

**Our clinic functions on a consultation basis. We may have to recommend establishing care with a general neurologist or cardiologist before seeing your patient.*

