SANTA CLARA
VALLEY MEDICAL CENTER
Hospital & Clinics

Pediatric Healthy Lifestyle Center
At VHC Tully, Bascom, East Valley, Tully,
Downtown, Milpitas, Sunnyvale and Gilroy
500 Tully Rd San Jose, CA 95111
Appointment: 408-957-8601
Tel: 408-817-1653 / Fax: 408-817-1409
scvmc.org

Dear Providers,

Thank you for your interest in referring your patient to SCVMC. All referrals must be entered on the *Santa Clara Valley Medical Center website* at https://scvmc.org/for-providers/ or go directly to https://na2.docusign.net/Member/PowerFormSigning.aspx?PowerFormId=e96a6a4a-ca91-41ac-960f-838eff22af74&activateonly=1 (take you to step 2)

Please follow this steps:

1) ***Select*** - How to Make a Referral then ***Click Referral Form*** in the Making a Referral for Outpatient Specialty

2) Enter your name and your email at "**PowerForm Signer Information**" the system will send you an email to review Document from VMC_AUTH@hhs.sccgov.org

3) Click Review Document from the DocuSign Link via Email – Will take you to the Referral Form

4) Enter referral and upload your documents

Please make sure you upload the requirements listed below. Incomplete Referrals/forms will cause a delay in processing.

Please ask your patient to call PHLC at 408 - 957 - 8601 for appointment after the referral is approved.

- Progress Notes (pertinent to diagnosis) and Growth Charts
- Reports (***labs Results of ALT, Lipids panel, Fasting Glucose & Hemoglobin A1C***, x-ray, CT scan, ultrasound, mammogram etc.)
- Copy of Insurance Card or Insurance Information and Registration Form
- Approved Authorization from Managing Agency (Excel, SCCIPA, CAP, etc.)

***Please note that the referral will not be processed until all information is received.*
Thanks, Pediatrics Healthy Lifestyle Center (PHLC)

Guidelines for Referral to the Pediatric Health Lifestyle Center (PHLC)

(rev 2020)

Patient with a BMI > 85% presents at Well Child or Well Teen Check:

- Review 10 Healthy Steps
- Identify areas where the family needs to make lifestyle changes
- Provide goals for the family to make those changes
- Order **fasting labs** for all children with a BMI >95% and ≥ 4 years old, and any child with risk factors*:
  - Lipid Panel
  - ALT
  - Fasting Glucose
  - Hemoglobin A1c
- Follow up in 2-3 months

Fasting Labs:

- Lipid panel
- Fasting glucose
- HgA1c
- ALT

***Risk Factors for Lipid Screening:**

- Primary relative with CVD in males < 55 yo or females< 65 yo
- Parents with TC ≥ 240 or known dyslipidemia
- DM, HTN, BMI > 95%
- Mod - high risk medical condition (Kawasaki, Chronic Inflam Dz, Nephrotic Syn)

At follow up:

- Evaluate family's progress with lifestyle changes and their readiness to change
- Identify challenges to change
  - Social/family issues *(consider referral to social work)*
  - Parents separated *(are they both ready to change?)*
  - Mental health/behavioral issues *(consider referral to mental health)*
- Review fasting labs
- Review PHLC program******

Elevated ALT → Management per NAFLD algorithm

A1c ≥ 6.2 → Referral to Endocrinology

Family is ready to change their lifestyle habits and are interested in PHLC → Referral to PHLC *Only 2 children per family please*

******Please inform families that PHLC is not a weight management clinic and that we focus on lifestyle habits, not weight. And please do not promise any specific resources such as free bicycles or gym memberships, as we cannot guarantee that families will qualify for those

SANTA CLARA VALLEY

REQUEST for CONSULT/REFERRAL

Place patient demographic sticker here.

Patient Name

Address

Phone

Medical Record #

Financial Class

Date _____

ORIGINATING CLINIC

Attending MD–*stamped name & signature* *Resident's name requires Attending stamp & signature*	Referring Clinic - *stamped*

STOP - Information requested above must be complete & legible, or this form will not be processed.

☐ **CONSULT** (Requesting opinion about a specific problem; requires feedback from consultant to provider initiating consult.)

☐ **REFERRAL** (Transferring care for a specific problem to another provider.)

requested for

☐ **Routine** ☐ Within One Month

☐ **ICD 10: 1)** _____ **2)** _____

3) _____ **4)** _____

Pediatric Healthy Lifestyle Center (PHLC)

What Specialty

☐ Within Two Weeks ***Requires prior conversation w/Specialist.**

Print name of Specialists and date of conversation here.

_____ _____

Specialist's Name Date

REASON FOR CONSULT / REFERRAL

(ATTACH PROGRESS NOTE & PERTINENT LABS, XRAYS, etc.)

Below this line for Referral Center and Specialist only.

Please Fax Referral with all the listed information below to (408) 793 – 1892

☐ Current Demographic Information (Face Sheet)
☐ Progress Notes
☐ Reports (Labs, X-Ray & etc.)
☐ Approved Authorization
☐ Copy of Insurance Card

Original to Chart - Copy to SCVMC Referral Center

SANTA CLARA VALLEY MEDICAL CENTER
REFERRAL REGISTRATION FORM

VHP / AUTHORIZATION CENTER
751 S. Bascom Ave San Jose, CA 95128
(408) 817-1653
Fax # (408) 793-1892

PATIENT'S DEMOGRAPHIC INFORMATION: **MUST COMPLETE**

LAST NAME: _____ ***FIRST***: _____ MIDDLE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ ***SEX***: M / F

HOME ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE / CELL #: (_____) _____ BIRTH PLACE: _____

U.S. CITIZEN: YES / NO MARITAL STATUS: _____ ETHNICITY: _____ COUNTY: _____

RELIGION: _____ ***LANGUAGE***: _____ ***MOTHER'S MAIDEN NAME (LAST)***: _____

ARE YOU EMPLOYED: YES / NO EMPLOYER NAME: _____ OCCUPATION: _____

INSURANCE INFORMATION: (PPO, HMO, MECI-CAL, & HEALTHY FAMILY OR KIDS)

INSURANCE TYPE: _____ GROUP # _____ PHONE (___) _____

I.D. #: _____ ***SUBSCRIBER'S NAME***: _____ ***DATE OF BIRTH***: _____

EMPLOYER NAME: _____ OCCUPATION: _____

INSURANCE BILLING ADDRESS: _____

GUARANTOR'S INFORMATION: ***MUST COMPLETE***

PARENT'S NAME: * _____ RELATIONSHIP: * _____

SOCIAL SECURITY #: _____ ***DATE OF BIRTH***: * _____

EMERGENCY CONTACT PERSON: (DIFFERENT TELEPHONE # FROM PT)

NAME: _____ **RELATIONSHIP**: _____

PHONE / CELL #: _(_____)_____

PLEASE FILL OUT THE INFORMATION ABOVE AND FAX IT BACK TO VMC AUTH DEPT. AS SOON AS POSSIBLE.
REGISTRATION FORM MUST BE COMPLETED & RETURN TO VMC AUTHORIZATION DEPARTMENT BEFORE YOUR APPOINTMENT. PLEASE FAX IT TO **(408) 793-1892.** THANK YOU!

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