



# Outpatient Referral Form

Thank you for your referral to Children's Hospital Los Angeles.  
Please submit this form for any outpatient service referrals.  
Please fax this form to:

**Fax: 323-361-8988**

Questions: [Phone: 888-631-2452](tel:888-631-2452) | [CHLA.org/Referrals](http://CHLA.org/Referrals)

\* Required Information

**Minimum Documentation needed to process referral -  
(a) most recent clinical note, (b) insurance info, and (c) demographics.**  
(Labs/growth charts/diagnostics, if available.)

\*Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## I: REFERRING PHYSICIAN INFORMATION

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

\*Office Phone #: \_\_\_\_\_ \*Office Fax #: \_\_\_\_\_

\*Email Address: \_\_\_\_\_ Office Contact Name (If other than MD): \_\_\_\_\_

## II: PATIENT & FAMILY INFORMATION

\*Patient First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Primary Language: \_\_\_\_\_

\*Parent/Guardian First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*Parent/Guardian DOB \_\_\_\_\_ \*Patient/Guardian Address: \_\_\_\_\_

\*Phone #: \_\_\_\_\_ Alt. Phone #: \_\_\_\_\_

## III: CLINICAL INFORMATION

URGENT  ROUTINE

\*Requested Specialty/Specialist: \_\_\_\_\_

\*Reason for Referral/Diagnosis: \_\_\_\_\_

\*Preferred Location:

Sunset Campus  Arcadia  Encino  Bakersfield  Santa Monica  South Bay  Valencia  Other: \_\_\_\_\_

## IV: INSURANCE INFORMATION

\*Patient Insurance Type:

Commercial PPO  Commercial HMO  Straight Medi-Cal  California Children's Services (CCS)

Medi-Cal Managed Care  Self Pay  Other \_\_\_\_\_

\*Insurance Carrier: \_\_\_\_\_

Subscriber ID #/CIN #: \_\_\_\_\_

**If prior authorization is required pursuant to your insurance carrier policy, please include a copy of authorization.**