ChildrensHospitalLosAngeles

International Leader in Pediatrics

*Denotes Required Information

New Patient Referral Form – All Clinics

Thank you for your referral to CHLA! This form is required by all of our clinics.
Some clinics require additional documentation prior to appointment scheduling.
Please call us or visit us on the web for further information & assistance.
This form & any supplemental information should be faxed to the clinic directly.

1-888-MD1-CHLA

http://www.childrenshospitalla.org

*Date: ____/____/____

SECTION I: REFERRING PHYSICIAN INFORMATION

*First Name: ______________________ *Last Name: ______________________

Office Address: ____

*Office Phone #: ______________________ *Office Fax #: ______________________

*Email Address: ______________________

SECTION II: PATIENT & FAMILY INFORMATION

*Patient First Name: ______________________ *Last Name: ______________________

*Date of Birth: ______________ Social Security #: ______________ Male___ Female___

*Parent/Guardian First Name: ______________________ *Last Name: ______________________

*Parent Phone #: ______________________ *Parent Alt. Phone #: ______________________

Primary Language: ______________ Has the patient been seen at CHLA before? Yes ___ No ___ Unknown ___

SECTION III: CLINICAL INFORMATION (Please see clinic-specific documentation requirements at http://www.childrenshospitalla.org)

*Reason for Referral:

____

____

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SECTION IV: INSURANCE INFORMATION

(Please complete insurance information below or fax a copy of insurance card [front/back].)

*Patient Insurance Type:

HMO _____ PPO _____ POS _____ CCS _____ Medi-Cal _____ Healthy Families _____ Medi-Cal Managed Care _____

*Insurance Carrier (if known): ____

Subscriber ID #: ______________________

Prior authorization is required for all non-PPO patients. Delays in obtaining authorization will delay appointment scheduling

(Please complete authorization information below or fax copy of authorization.)

If applicable:

*Authorization #: ______________________ *Expiration Date: ______________

Last Revised 9/08