



ChildrensHospitalLosAngeles

International Leader in Pediatrics

Dermatology Clinic
New Patient Referral Requirements

5000 Sunset Blvd., 4th Floor, Los Angeles, CA 90027

Phone: 323-361-4191

Fax: 323-953-8116

Please complete and fax to the number above. Thank you!

Date: ____/____/____

Patient First Name: _____ Last Name: _____

ADDITIONAL REFERRAL INFORMATION REQUIRED

Delays in obtaining documentation will delay appointment scheduling

I. CHLA "NEW PATIENT REFERRAL FORM - ALL CLINICS" MUST BE COMPLETED

II. ADDITIONAL PATIENT INFORMATION - NONE REQUESTED

III. CLINICAL DOCUMENTATION REQUESTED (Checklist Below):

____ The last three (3) doctor's notes

____ Any lab results

____ Any x-ray results

IV. AUTHORIZATION REQUESTED (If non-PPO Patient)