Endocrinology Clinic
New Patient Referral Requirements

4650 Sunset Blvd., Mailstop #61, Los Angeles, CA 90027
Phone: 323-361-4604
Fax: 323-361-8065

ChildrensHospitalLosAngeles
International Leader in Pediatrics

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

Patient Height: _____ cm _____ in

Mother Height: _____ cm _____ in

Father Height: _____ cm _____ in

Weight: _____ kg _____ lbs

BMI: _____

Age: Years_____ Months _____

Diagnosis: _____

Nature of Complaint: _____

Medications: _____

III. CLINICAL DOCUMENTATION REQUESTED

Lab Results: ( ) Attached ( ) Not Available

History & Physical: ( ) Attached ( ) Not Available

Growth Chart: ( ) Attached ( ) Not Available

( ) Bone age x-ray if completed

( ) CHLA Consult Report (if applicable)

PHYSICIAN REQUESTED:

____ Borut ____ Geffner

____ Fisher ____ Kaufman

____ Chao ____ Jeandron

____ Kim ____ Mittelman

____ Monzavi ____ Pitukcheewanont

____ Sandstrom ____ Wood

____ Any Provider

IV. AUTHORIZATION REQUESTED (If non-PPO Patient):

_____ Authorization for 1 Registered Dietician Visit (CPT 97802)