



Medical Genetics Clinic New Patient Referral Requirements

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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 - NONE REQUESTED

III. CLINICAL DOCUMENTATION REQUESTED:

___ Pertinent Lab Results/Reports

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

___ 99245 x 4

___ 97802 x 4

___ 97802 - Separate Authorization for CHLA/Nutrition

___ S0265 x 24 (HMO & Medi-Cal Only)

PHYSICIAN REQUESTED:

___ Boles ___ Randolph

___ Wong ___ GC

___ Sanchez

___ Neurocutaneous Clinic

___ Any Provider