



**Children's Hospital Los Angeles**

*International Leader in Pediatrics*

**Pediatric Surgery Office**  
**New Patient Referral Requirements**  
4650 Sunset Blvd., MS #106, Los Angeles, CA 90027  
Phone: 323-361-2322 ~ Fax: 323-361-4775

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):**

A. Please fax results and plan to bring the films with you. Thanks!

\_\_\_\_ Any x-ray results                      \_\_\_\_ Any ultrasound results  
\_\_\_\_ Any CT scan results                      \_\_\_\_ Any MRI results

B. Has your child had surgery previously for this condition?

\_\_\_\_ Yes                      \_\_\_\_ No  
\_\_\_\_ If yes, please fax the Operative Report

C. Physician Requested

Please indicate your preference:

\_\_\_\_ Next available appointment  
\_\_\_\_ Specify surgeon: Dr. \_\_\_\_\_

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

Patient insurance card is required at the time of appointment.