



ChildrensHospitalLosAngeles
International Leader in Pediatrics

Vision Center
New Patient Referral Requirements
4650 Sunset Blvd., MS#88, Los Angeles, CA 90027
Phone: 323-361-2347
Fax: 323-361-3524

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 REQUIRED

III. CLINICAL DOCUMENTATION REQUESTED:

___ Diagnosis & clinical/progress/eye notes

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

Authorization for the following CPT codes is required:

___ 99244 - New Patient

___ 92015 - Refraction

___ 92060 - Sensorimotor Exam for Ocular Motility

Glaucoma referrals also require:

___ 92083 HVF

___ 92135 OCT

___ 92250 Fundus Photo