



Allergy/Immunology Clinic New Patient Referral Requirements

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Phone: 323-361-2501

Fax: 323-361-1191

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 (Checklist Below):

Please describe any other significant medical issues:

Please either fax results or bring the films. Thanks!

- _____ Immunization record
- _____ Any lab results
- _____ Any x-ray results
- _____ Any other pertinent test results

IV. AUTHORIZATION REQUESTED (If non-PPO Patient)

Name & Contact Information for Physician to Receive Consult Report:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____