



Diabetes 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:

Type of Diabetes (Circle 1): Type 1 Type 2 Secondary Unknown

Diagnosis Date: ____/____/____

Last Physician Appointment Date: ____/____/____

Last HbA1C Result: _____

Any Severe Lows (Circle 1)? Yes No

If Yes:

When: ____/____/____

Was child unconscious? Yes No

Did you give Glucagon? Yes No

Did child have a seizure? Yes No

Did you call 911? Yes No

Type of Medications (Circle all that Apply):

Insulin Humalog Novolog RegularNPH Lente Ultralente 70/30 Lantus

III. CLINICAL DOCUMENTATION REQUESTED:

Lab Results: () Attached () Not Available

History & Physical: () Attached () Not Available

Growth Chart: () Attached () Not Available

() CHLA consult report (if applicable)

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

____ Authorization for MD Consult (CPT 99244or 99245)

____ Authorization for RD Consult (CPT 97802)

____ Authorization for 3 Registered Dietician Visits (CPT 97803)

PHYSICIAN REQUESTED:

____ Borut ____ Haddal

____ Fisher ____ Geffner

____ Jeandron ____ Kaufman

____ Monzavi ____ Mittelman

____ Chao

____ Pitukcheewanont

____ Any Provider