



Infectious Disease Clinic New Patient Referral Requirements

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Children's Hospital Los Angeles

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:

- Brief History & Physical Report (Last clinic note)
- Pertinent Lab Results/Reports
- Immunization Record (Please ask family to bring this to the Clinic if you do not have it)
- Medication Form (See below)

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

- Authorization for the Following Lab Services:
 - CBC with Diff (CPT: 85025)
 - ESR (CPT: 85651)
 - CRP (CPT: 86140)
 - Chem Panel (CPT: 80053)



Medication List/Lista de Medicamentos

Patient/Family/Guardian Instructions: Please write down every medication the patient takes – *prescription or over-the-counter drugs, vitamins, herbal products and dietary supplements*. Please write down the whole name of the medication.

Instrucciones para el Paciente/Familia/Guardián: Escriba cada medicamento que el paciente toma, *con receta o sin receta, vitaminas, productos herbales y suplementos dietéticos*. Escriba el nombre completo del medicamento.

		MD/NP/Dentist/PA to Complete Personal médico necesita completar		
Drug Name/ Nombre del Medicamento	How do you take your medication? Como toma su medicamento?	Discharge Medication Reconciliation		Start/ Comenzar
		Per Prescribing MD/ Por Médico que receta	Stop/ Parar	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments/Comentarios		MD/NP/Dentist/PA Name/Signature: Nombre/Firma de personal medico		
		Date/Fecha:		

Childrens Hospital Los Angeles
 Medication Reconciliation

_____ Clinic