



# Nephrology 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 - NONE REQUESTED**

### **III. CLINICAL DOCUMENTATION REQUESTED:**

Lab Results:     Attached     Not Available

X-Ray Results:  Attached     Not Available

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

**PHYSICIAN REQUESTED:**

\_\_\_ CMG            \_\_\_ GL

\_\_\_ KL            \_\_\_ Any Provider