



ChildrensHospitalLosAngeles

International Leader in Pediatrics

**Plastic Surgery Clinic
Craniofacial Clinic
New Patient Referral Requirements**

4650 Sunset Blvd., MS #96, Los Angeles, CA 90027

Phone: 323-361-5682

Fax: 323-361-3632

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):

____ The last three (3) doctor's notes

____ Any lab results

____ Any x-ray results

IV. AUTHORIZATION REQUESTED (If non-PPO Patient)