ChildrensHospitalLosAngeles
International Leader in Pediatrics

Pulmonary Clinic
New Patient Referral Requirements

4650 Sunset Blvd. MS #127, LA, CA 90027
Phone: 323-361-2287 or 323-361-5158
Fax: 323-361-4533

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

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I. CHLA "NEW PATIENT REFERRAL FORM – ALL CLINICS" MUST BE COMPLETED

II. ADDITIONAL PATIENT INFORMATION – NONE REQUESTED

III. CLINICAL DOCUMENTATION REQUESTED:

____ Most current MD consult note (specify patient diagnosis)

____ Pertinent Lab Results/Reports

____ Please advise patient to bring all x-rays to the visit

IV. AUTHORIZATION REQUESTED (If non-PPO Patient)

____ Pulmonary Consultation (CPT 99244, 99245)

____ Overnight Sleep Study (CPT 95810)

____ Overnight Sleep Study for CPAP/BIPAP (CPT 95811)

____ Sweat Chloride Test (CPT 89230)

____ Pulmonary Function Test (CPT 94010; 94260; 94760; 94240; 94370)

____ Chest X-Ray (CPT 71020)

____ Medical Nutrition Consult (CPT 97802) x 4 units (15 minutes per unit)

____ CF Sputum Specimen (CPT 87070)

____ CF DNA Blood Test (CPT 83891; 83894; 83898; 83904; 83909; 83912)

PHYSICIAN REQUESTED:

___ Margetis ___ Keens

___ LaGuardia ___ Lew

___ MacLaughlin ___ Ward

___ Platzker ___ Perez

___ Any Provider