**Intake Form**

Thank you for considering Children’s Hospital Los Angeles for your child’s medical needs. To provide the most comprehensive care, please complete this form and return it with the documents listed on the checklist. Once this form has been completed, please return the information by fax or email.

Our International Patient Services staff will submit this information along with your child’s medical records to our medical team to determine the most appropriate treatment/next steps.

**Today’s Date (Month ##, Year):** Click here to enter a date.

**A: PATIENT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | | | |  |
| **Last Name** | **First Name** | | | | **Middle Initial** |
| Click here to enter a date. |  | **M** **F** |  | | |
| **Date of Birth (Month ##, Year)** | **Age** | **Gender** | **Country of Citizenship** | | |
|  |  | | | | |
| **Place of Birth** | **Country of Residence** | | | | |
|  | | | |  | |
| **Diagnosis** | | | | **Symptom(s)** | |

**B: FAMILY AND CONTACT INFORMATION**

***Parent #1***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | |  | |
| **Last Name** | **First Name** | | | | **Middle Initial** | |
| Click here to enter a date. | **M** **F** |  | |  | | |
| **Date of Birth (Month ##, Year)** | **Gender** | **Relation to Patient** | | **Country of Residence** | | |
|  |  | | | | | |
| **Phone Number** | **Email Address** | | | | | |
|  | | | | | | |
| **Primary Language** | | | | | | |
|  | | | | |  | |
| **Name of Employer** | | | | | **Phone Number of Employer** | |
|  | | |  |  |  |  |
| **Work Address** | | | **City** | **State** | **Zip** | **Country** |

**B: FAMILY AND CONTACT INFORMATION (CTD.)**

***Parent #2***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | |  | |
| **Last Name** | **First Name** | | | | **Middle Initial** | |
| Click here to enter a date. | **M** **F** |  | |  | | |
| **Date of Birth (Month ##, Year)** | **Gender** | **Relation to Patient** | | **Country of Residence** | | |
|  |  | | | | | |
| **Phone Number** | **Email Address** | | | | | |
|  | | | | | | |
| **Primary Language** | | | | | | |
|  | | | | |  | |
| **Name of Employer** | | | | | **Phone Number of Employer** | |
|  | | |  |  |  |  |
| **Work Address** | | | **City** | **State** | **Zip** | **Country** |

***Other Contact (If Applicable)***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | | | |  | |
| **Last Name** | **First Name** | | | | **Middle Initial** | |
| Click here to enter a date. | **M** **F** |  | |  | | |
| **Date of Birth (Month ##, Year)** | **Gender** | **Relation to Patient** | | **Country of Residence** | | |
|  |  | | | | | |
| **Phone Number** | **Email Address** | | | | | |
|  | | | | | | |
| **Primary Language** | | | | | | |
|  | | | | |  | |
| **Name of Employer** | | | | | **Phone Number of Employer** | |
|  | | |  |  |  |  |
| **Work Address** | | | **City** | **State** | **Zip** | **Country** |

**C: CLINICAL INFORMATION**

***Referring Physician***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| **Last Name** | **First Name** | | **Middle Initial** |
|  |  | | |
| **Phone Number** | **Email Address** | | |
|  | |  |  |
| **Name of Hospital/Organization** | | **City** | **Country** |

**C: CLINICAL INFORMATION (CTD.)**

***Primary Care Physician***

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| **Last Name** | **First Name** | | **Middle Initial** |
|  |  | | |
| **Phone Number** | **Email Address** | | |
|  | |  |  |
| **Name of Hospital/Organization** | | **City** | **Country** |

**D: RESIDENCE INFORMATION**

***Permanent Residence***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Address** | **City** | **State** | **Zip** | **Country** |
|  |  | | | |
| **Home Phone Number** | **Other Phone Number** | | | |

***Temporary Residence***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Address** | **City** | **State** | **Zip** | **Country** |
|  |  | | | |
| **Temporary Phone Number** | **Other Phone Number** | | | |

**E: PAYMENT INFORMATION**

Government/Embassy Sponsored:  Self-Pay:  Insured\*:  Other:

**If other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*Please attach copies of the front and back of all insurance cards***

**F: TRAVEL INFORMATION**

**Timeframe you plan on traveling to Los Angeles/Children’s Hospital Los Angeles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**G: ADDITIONAL INFORMATION**

|  |
| --- |
| **How did you hear about us?** Internet Search Engine  Children’s Hospital Los Angeles Website  Government/Embassy External Physician  Family/Friend  Foundation  Children’s Hospital Los Angeles Physician Insurance Company Employer Other  **If other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **What are you most interested in seeking?** Consultation  Treatment  Both |

**G: ADDITIONAL INFORMATION (CTD.)**

|  |
| --- |
| **What is the reason for your referral to Children’s Hospital Los Angeles? Please check all that apply.**    New Diagnostic Evaluation Develop Medical Management Plan  Continue Current Treatment  Surgical Opinion Surgical Management Second Opinion/Review of Medical Workup/Treatment Plan  Other  **If other (ex. seeking specific treatment, etc.), please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **What is your family’s ethnicity?** |
| **What is your family’s preferred spoken language?** |
| **Would you like us to provide an interpreter for your family during the medical visit?** Yes  No |
| **What is your family’s spiritual affiliation?** |
| **Are there any special needs that we should be aware of?** |

**H: CHECKLIST**

|  |  |
| --- | --- |
| **Required Forms and Documentation** | **Please Indicate: Yes, No, or Not Applicable (N/A)** |
| 1. **Valid Photo ID and/or Passport** | Yes  No  N/A |
| 1. **Intake Form** | Yes  No  N/A |
| 1. **HIPAA - Consent to Release Medical Information Form** | Yes  No  N/A |
| 1. **Copies of Insurance Card (if applicable)** | Yes  No  N/A |
| 1. **Current History & Physical Information** | Yes  No  N/A |
| 1. **Recent Laboratory and Pathology Reports** | Yes  No  N/A |
| 1. **Recent Radiology Reports and Films/CDs** | Yes  No  N/A |
| 1. **Other (Specialist Medical Reports, Summary Letter from Patient’s Primary Care Physician, etc.)** | Yes  No  N/A |

Below is a list of required forms and documentation needed to begin the review process. If there are any medical records that are not available, please indicate why. Please note that all medical records must be submitted in **ENGLISH**. Unfortunately, without the appropriate medical records, we cannot process your referral. Our medical team may request that specific tests or evaluations be completed before visiting Children’s Hospital Los Angeles.