Outpatient Referral Form

Thank you for your referral to Children's Hospital Los Angeles!
Please submit this form for any outpatient service referrals.
Please fax or email this form to us at:

Email: MD1@chla.usc.edu
Fax: 323-361-8988

*** Required Information**

Questions? Please contact us!
Ph: 888-631-2452 | CHLA.org/Referrals

*Date: _____/_____/_____

I: REFERRING PHYSICIAN INFORMATION

*First Name: _____ *Last Name: _____

Office Address: _____

*Office Phone #: _____*Office Fax #: _____

*Email Address: _____ Office Contact Name (If other than MD):_____

II: PATIENT & FAMILY INFORMATION

*Patient First Name: _____*Last Name: _____

*Date of Birth: _____ Male ____ Female ____ Primary Language: _____

*Parent/Guardian First Name: _____ *Last Name: _____

*Phone #: _____ Alt. Phone #: _____

Has the patient been seen at CHLA before? Yes ___ No ___ Unknown ___

III: CLINICAL INFORMATION

*Requested Specialty/Specialist: _____

*Reason for Referral: _____

_____

_____

_____

*Preferred Location:

☐ Los Angeles-Main Campus ☐ Arcadia ☐ Santa Monica ☐ South Bay ☐ Valencia ☐ Other: _____

IV: INSURANCE INFORMATION

*Patient Insurance Type:

Commercial PPO _____ Commercial HMO _____ Straight Medi-Cal _____ California Children's Services (CCS) _____

*Insurance Carrier: _____

Subscriber ID #: _____

***Prior authorization is required for all non-PPO patients. Please complete authorization information below or fax copy of authorization.**

If applicable: *Authorization #: _____ *Expiration Date: _____