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 this form to:

Fax: 323-361-8988

Questions: Phone: 888-631-2452 | CHLA.org/Referrals

*** Required Information**

Minimum Documentation needed to process referral -
(a) most recent clinical note, (b) insurance info, and (c) demographics.
(Labs/growth charts/diagnostics, if available.)

*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: _____

*Parent/Guardian DOB _____ *Patient/Guardian Address: _____
__

*Phone #: _____ Alt. Phone #: _____

III: CLINICAL INFORMATION

☐ URGENT ☐ ROUTINE

*Requested Specialty/Specialist:_____

*Reason for Referral/Diagnosis:_____

_____

*Preferred Location:

☐Sunset Campus ☐Arcadia ☐Encino ☐Bakersfield ☐Santa Monica ☐South Bay ☐Valencia ☐Other: _____

IV: INSURANCE INFORMATION

*Patient Insurance Type:

☐Commercial PPO ☐Commercial HMO ☐Straight Medi-Cal ☐California Children's Services (CCS)
☐Medi-Cal Managed Care ☐Self Pay ☐Other _____

*Insurance Carrier: _____

Subscriber ID #/CIN #: _____

***If prior authorization is required pursuant to your insurance carrier policy, please include a copy of authorization.**