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

Questions? Please contact us!
Phone: 1-888-631-2452 | CHLA.org/Referrals

* Required Information

Date: _____/_____/_____

I: REFERRING PHYSICIAN INFORMATION

*First Name: _____ *Last Name: _____

Office Address: _____

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

*Email Address: _____ Office Contact (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 here before? Yes ___ No___ Unknown___

III: CLINICAL INFORMATION

*Reason for Referral:

_____

_____

IV: INSURANCE INFORMATION

*Patient Insurance Type:

Commercial PPO ____ Commercial HMO____ Straight Medi-Cal ____ California Children's Services (CCS) ____

Insurance Carrier: _____

Subscriber ID #: _____