CHOC Children's Specialists

Division of Adolescent Medicine Referral Request

Division Phone: 714-509-7171 CHOC Scheduling Line 1-888-770-2462 Fax: 1-855-212-6740

Thank you for referring your patient to the Division of Adolescent Medicine.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance: _____ Parent Cell: _____

1. Is this an **emergent** Adolescent referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD /PA /NP with clinical information to 714.509-4013.**

2. Please describe the patient's chief complaint and include onset and laboratory results:

_____

_____

_____

3. What is the key question you would like us to answer?

_____

_____

_____

To expedite appointment scheduling, please provide the following by FAX 1-855-212-6740:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Pertinent laboratory results and growth charts**
- ☐ **Patient demographics**
- ☐ **Authorizations 99245 Consult, or 99205 New Patient, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____