CHOC Children's Specialists

Division of Allergy & Immunology Referral Request

Division Phone: 714.633.6363 CHOC Scheduling Line 1-888-770-2462 Fax: 1-855-246-2329

Thank you for referring your patient to the Division of Allergy & Immunology.

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** Allergy referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD /PA /NP with clinical information to 714.633.6363**

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

_____

_____

_____

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

_____

_____

_____

To expedite appointment scheduling, please provide the following by FAX: 1-855-246-2329

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Pertinent laboratory results**
- ☐ **Patient demographics**
- ☐ **CPT Codes required for new patient visit: 99245 x1; 95004 x90; 94664 x1; 94010 x 2; 94375 x1**
- ☐ **Authorization, or if not applicable, a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____