CHOC Children's

Brachial Plexus Injury Clinic

Scheduling Phone: 888-770-2462 Fax: 855-246-2329 Division Phone: 714-509-7981

Thank you for referring your patient to the Brachial Plexus Injury Clinic at CHOC.

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** referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD/PA/NP with clinical information to 714.509.7981**

2. Please describe the patient's diagnosis at birth and chief complaint:

_____

_____

_____

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

- ☐ **This completed form**
- ☐ **Medical records related to the diagnosis and chief complaint including OR notes and radiology reports**
- ☐ **Lab and test reports within the last year**
- ☐ **Patient demographics**
- ☐ **Authorization including CPT codes:**
  - **99205 for Brachial Plexus Consult**
  - **97165 (1) for Occupational Therapy Consult**
  - **97161 (1) for Physical Therapy Consult**
  - ***Cal Optima patients please include Z7500**
  - **If codes not applicable please include a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax: _____

Provider Address: _____ City: _____ Zip: _____

Provider Signature: _____ **Date:** _____ **Time:** _____

Updated on 09/25/2023