CHOC Children's Specialists

Division of Metabolic Disorders Referral Request

Division Phone: 714.509.8852 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Metabolic Disorders.

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** Metabolic referral? ☐ No ☐ Yes **If yes, the referral requires a phone call from an MD /PA /NP with clinical information to 714.509.8852**

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

_____

_____

_____

3. What is the main concern you would like us to address?

_____

_____

_____

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

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Pertinent laboratory results**
- ☐ **Patient demographics**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____