CHOC Children's

Division of Orthopaedics Referral Request

CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Orthopaedics.

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** Orthopaedic 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 want us to answer?

4. Please select one of the following:

- ☐ **Fracture (FX)**
- ☐ **General Surgery**
- ☐ **Spina Bifida**
- ☐ **Spasticity**
- ☐ **Other**_____

5. Authorizations

a) Send a copy of the authorization with CPT codes 99205 & Z7500 (for CHOC facility) for all referrals.

b) Authorizations made out to:
Pediatric Orthopaedic Specialists of Orange County
1310 West Stewart Dr., ste#508
Orange, CA 92868

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

- ☐ **This completed form**
- ☐ **Patient demographics**
- ☐ **Radiology reports or XR/MRI reports**
- ☐ **Medical records related to the chief complaint**
- ☐ **Authorization, if not applicable, a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax: _____

Provider Address: _____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____