CHOC Children's

Pulmonology Referral Request

CHOC Scheduling 888.770.2462 Fax: 855.246.2329

Please Indicate Physician Group- Required

☐ **CHOC Children's Specialists**

Anchalee Yeungsrigul, M.D. Chana Chin, M.D.
Susan Gage, M.D. Amy Harrison, M.D.
David Hicks, M.D. Sunil Kamath, M.D.
Neal Nakra, M.D. Pornchai Tirakitsoontorn, M.D.

☐ **UCI**

Dan Cooper, M.D.
Kim Lu, M.D.

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: _____

1. Is this an **emergent** Pulmonary 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 frequency*:

_____

_____

Please select diagnosis: ***Pre referral work up requirements by diagnosis:***

☐ **Asthma**	► Asthma; chest x-ray (film and report), Allergy testing, notes from other consultants
☐ **Apnea**	► Sleep apnea; sleep study, NICU notes and discharge summary, notes from other consultants
☐ **General Pulmonary**	► Including but not limited to: chronic lung disease, chronic cough, immunology disorders; chest x-ray (film and report), notes from other consultants

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

- ☐ **This completed form, patient demographics and insurance card copy**
- ☐ **Medical records related to the chief complaint. Lab and test reports from the last year including respiratory cultures, pulmonary function and allergy testing/immune testing if applicable**
- ☐ **Authorization CPT code 99245 Consult, and if >5yr add CPT 94375 Flow Volume loop**

  ****CalOptima patients require an additional CPT code Z7500**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

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