CHOC Children's Specialists

Division of Cardiothoracic Surgery Referral Request

Division Phone: 714-509-4641 CHOC Children's Scheduling Line 888-770-2462 Fax: 855-246-2329

Thank you for referring your patient to the Division of Cardiothoracic Surgery.

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** Cardiothoracic Surgery 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. Was the patient seen by a Cardiologist ☐ No ☐ Yes (please include notes)

Provider Name: _____

Date last seen:_____

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

- ☐ **This completed form**
- ☐ **Patient demographics**
- ☐ **Medical records related to the chief complaint**
- ☐ **Pertinent laboratory results and ECHO. If ECHO is not from CHOC, patient must bring disk or report to the appointment**
- ☐ **Authorization including CPT Code 99245, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax: _____

Provider Address: _____ City: _____ Zip: _____

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