Mattel Children's Hospital UCLA

Medical Home Referral Form

Phone: (310) 825-0867 ext 171924
Fax: (310) 267-0261
Email: pedsmedicalhome@mednet.ucla.edu

Please answer the following questions:

1. Is the patient interested in receiving pediatric care at the UCLA Pediatric Resident Clinic at CHC? Yes No

2. Is the patient under the care of at least two subspecialists on a regular basis? Yes No

3. Does the patient have one or more conditions for which he/she receives CCS? Yes No

4. Does the patient have insurance accepted at UCLA Pediatric Resident Clinic at CHC for primary care? Yes No

** If all answers 1 - 4 are "yes", please proceed to fill out the rest of the form and submit the referral. Please contact our office if you have any questions regarding your patient's eligibility **

Patient Name ______________________

UCLA MR # ______________________

DOB ______________________

Caregiver's Name ______________________

Caregiver's Relationship to Patient ______________________

Caregiver's Phone # ______________________

Alternate Phone # ______________________

Referred by / Title ______________________

Phone # / Pager ID ______________________

Is your patient a transplant recipient or expected to need an organ transplant in the near future? Yes No

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Patient's Diagnoses ______________________

Reason(s) for Referral ______________________

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Please list current subspecialist(s) caring for the patient (optional)

MD Name	Specialty	Location	Frequency of Visits

Comments ______________________

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Please submit the completed form to the Medical Home office by fax: (310) 267-0261 or email: pedsmedicalhome@mednet.ucla.edu.
Thank you!

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