Mattel Children's Hospital UCLA

MRN:
Patient Name:

(Patient Label)

REFERRAL FORM
Pediatric Surgery

☐ **DeUgarte, Daniel MD** ☐ **Dunn, James MD** ☐ **Lee, Steven MD** ☐ **Shew, Stephen MD**

Phone: (310) 206-2429 Fax: (310) 206-1120

Date: _____

REFERRING PHYSICIAN INFORMATION:

Name: _____

Address: _____

Office Phone: _____ Office Fax: _____

PATIENT and FAMILY INFORMATION:

Name: _____

Date of Birth: _____ Social Security #: _____ ☐ Male ☐ Female

Parent/Guardian Name: _____ Date of Birth: _____

Address: _____ Phone: _____

CLINICAL INFORMATION: *(Please fax pertinent medical records, i.e., labs, x-ray and scans)*

Reason for Referral: _____

_____

_____

_____

_____

INSURANCE INFORMATION: *(Please fax a copy of insurance card, front/back)*

☐ HMO ☐ PPO ☐ POS ☐ CCS ☐ MEDI-CAL

Insurance Carrier: _____

Subscriber Name: _____ Subscriber ID #: _____

Prior authorization is required fro all non-PPO patients.

Authorization #: _____ Expiration Date: _____

Thank you for your referral to UCLA PEDIATRIC SURGERY!
We will contact your patient.
Appointments will usually be scheduled within 5 business days.