CHOC Children's Specialists

Division of Infectious Diseases Referral Request

Division Phone: 714.509.8403 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Infectious Diseases.

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** infectious disease referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD or RN with clinical information to 714.509.8403**

2. Please describe the patient's chief complaint:

_____

_____

_____

_____

_____

3. What is the key question you want us to answer?_____

_____

_____

_____

_____

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

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Prior immunization records and lab results**
- ☐ **Growth chart**
- ☐ **Radiology reports**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Signature: _____ **Date: _____**