Department of Radiology/Imaging Services

4650 Sunset Boulevard, Los Angeles CA 90027
Phone: 1-888-MD1-CHLA (888-631-2452)
Fax: 323-361-8988
Radiology Referral Line (323)361-2411
Email: md1@chla.usc.edu

Thank you for referring your patient to the Radiology Department at Children's Hospital Los Angeles!

The following patient documentation is required in order to process your patient's appointment:

- Please fax back this form along with all required documents. Note: request cannot be processed without this form and all required documents needed.

REQUIRED DOCUMENTATION NEEDED TO SCHEDULE:

(Please be sure to provide the **PATIENT NAME & DATE OF BIRTH** on *all* documents submitted)

- **Pre-scheduling Evaluation Form** (see attached; to be fully completed by an **MD only**)
- **Signed Doctor's Order (Rx) which includes:**
  a) Doctor's name, address, phone number, CA Med License and NPI number
  b) Patient's name & date of birth
  c) Study requested
  d) Diagnosis with ICD10 code (R/O is not accepted)
- **Recent Clinical Notes**
- **Insurance information** (clear copy of insurance card)
- ***Approved* Authorization* and TAR** if applicable (need hard copy of authorization)
- **Patient Demographic sheet** (need two patient telephone numbers, if available)
- **Any applicable Court Documentation (for cases involving adoption, legal guardianship or foster care programs)**

Is patient under the care of the court, foster home, group home or DCFS?

☐ NO
☐ Yes, If Yes please circle one:
Foster home, court consent, group home, DCFS or other _____

*Please provide Name & phone number for social worker: _____

***Authorizations (must be obtained by the referring MD's office)**

- Please note the following regarding MRI AUTHORIZATIONS:
  - Medi-Cal Plans: TAR is required (approval can take 6-10 weeks)
  - HMO & Medi-Cal Managed Care Plans: Authorization required
  - California PPO Plans: Pre-Certification required for most plans
- Please include CPT Code 01922 for all MRI exams that require sedation

Submit your request via:
Fax: 323-361-8988
Email: md1@chla.usc.edu

Radiology will call the patient/family directly to schedule the appointment once we have received all appropriate documentation

Children's Hospital LOS ANGELES
We Treat Kids Better
Department of Radiology
Imaging Services

Department of Radiology/Imaging Services
Pre-Scheduling Evaluation Form
4650 Sunset Blvd., MS #81, L.A. CA 90027
Phone: 323-361-2411, Press option 3, then select Modality
Physician Referral Hotline: 1-888-MD1-CHLA, Fax: 323-361-8988

TO BE FULLY COMPLETED BY ORDERING PHYSICIAN

Date:_____

Ordering MD (Print name):_____Pager/Phone #: _____ Fax #:_____
Requested Exam: _____ Note: Contrast may be administered based on Radiologist's discretion
Dx:_____Date Needed by: _____
Clinical Reason for Exam (r/o may not be used): _____

PLEASE SUBMIT SEPARATE DOCTOR'S ORDER (PRESCRIPTION) FOR THE STUDY BEING REQUESTED

Patient's First Name:_____Last Name:_____ Date of Birth:_____
Telephone #: _____ Alternate Tel # or Email Address_____
Current Weight:_____ kg/lb Height: _____cm/inches BMI _____

Need for Anesthesia: Will patient be able to lie still for 3 to 5 minute intervals for a minimum duration of:
CT Scan for approx. 5 to 10 minutes? ☐ No ☐ Yes
MRI minimum duration of 1 hour (3 to 5 minute intervals)? ☐ No ☐ Yes

Does patient have any contrast allergies? ☐ No ☐ Yes
Names contrast(s)_____Reaction_____
Does patient have any renal issues/failures? ☐ No ☐ Yes_____

For ALL MRI patients:
Does patient have Ventriculoperitoneal Shunt (VPS)?: ☐ No ☐ Yes _____
If yes, the VPS is ☐ Non programmable ☐ Programmable If programmable, Type:_____ Setting:_____
Does patient have a trach? ☐ No ☐ Yes _____
Type of Trach: ☐ Shiley ☐ Bivona ☐ Other_____ Size of Trach:_____mm ☐ Ped/Adult ☐ cuffed/uncuffed
Pacemaker and/or Pacemaker wires? ☐ No ☐ Yes _____
Vagal Nerve Stimulator/Deep Brain Stimulator? ☐ No ☐ Yes _____

Metal [Specifically Metal Spinal Rods/Metal Hardware/Piercings/Dental Braces] ☐ No ☐ Yes _____
Machine/Equipment: Ventilator/Feeding/Insulin/Pain Pumps ☐ No ☐ Yes _____
If "yes" for ventilator, is patient ventilator dependent? ☐ No ☐ Yes _____

IF PATIENT DOES NOT REQUIRE ANESTHESIA: STOP

IF PATIENT REQUIRES ANESTHESIA, PLEASE CONTINUE TO ANSWER THE FOLLOWING QUESTIONS: GO
If any questions are "Yes", please explain in the space provides as well as provide requested documentation.
Prematurity? ☐ No ☐ Yes **Length of Gestation(wks)**: _____

Patient followed by Pulmonary? ☐ No ☐ Yes _____
If yes, provide Pulmonologist's name/phone number/ date of last visit (**Attach recent pulmonology notes**):
_____

☐CPAP ☐BiPAP ☐O2 ☐Other:_____ _____
Sleep Apnea/Airway Issues/Sleep Study?(**Attach Sleep Study Results**) ☐ No ☐ Yes
Complex Cardiac Disease/Decreased Cardiac Function ☐ No ☐ Yes _____
If yes, provide Cardiologist's name/phone number/ date of last visit (**Attach recent cardiology note & echo**):
_____

Check all that apply: ☐Autism|☐ADD|☐ADHD|☐Developmental Delay|☐Claustrophobia|☐Seizure disorder|☐Dystonia|

Diabetes? ☐ No ☐ Yes _____
Metabolic Disorder/Syndrome/Mitochondrial Disease? ☐ No ☐ Yes _____
Panhypopituitarism- ☐ No ☐ Yes _____
If yes, provide Endocrinologist's name/phone number/ date of visit (**Attach recent Endocrin notes**):
_____

Other: _____