LOMA LINDA UNIVERSITY
CHILDREN'S HOSPITAL

New Patient Referral Form
909-558-5138

Date: ___/___/___

Patient Information

First Name: ____________________________ Last Name: _________________________________

Date of Birth: _______________ Male____ Female ____ Phone number: ____________________

Parent/Guardian First Name: _______________________ Last Name: _______________________

Address: ____

City: ______________________ State: ___________________ Zip Code: ____________________

Insurance Information

Insurance Carrier ____

Subscriber ID #: ____

Referring Provider

First Name: ____________________________ Last Name: ________________________________

Office Address: ____

City: _______________________ State: __________________ Zip Code: ___________________

Office phone #: _________________________ Office fax #: ______________________________

Patient Medical Information

Reason for Referral: ____

Has the patient been previously seen at Loma Linda _____Yes _____ No

If yes, with what provider ____

Please fax the following documentation along with this form to 909-835-1855 to request an appointment for the patient.

1. Medical records from referring physician
2. Medical records from previous Endocrinologist
3. Diabetes diagnostic labs (C-peptide and glucose levels, Islet autoantibodies, & other autoimmunity screening at time of diagnosis)"
4. Recent A1c results (within 3 months of referral)

Thank you for your referral to Loma Linda Children's Hospital Pediatric Diabetes Center!