The Children's Hospital of San Antonio™
CHRISTUS Health

Everything for our children.™

Baylor College of Medicine

PEDIATRIC PRIMARY CARE CLINIC
Baylor College of Medicine
The Children's Hospital of San Antonio
Office: 210.704.4966
Fax: 210.704.2532

Children's Complex Care Program Referral

The Children's Complex Care Program offers pediatric primary care for patients with complex medical needs. Once we receive the completed form, the Complex Care team will review and notify the referring physician and/or child's family regarding acceptance within two weeks. Thank for your interest in our Complex Care program.

Please fax this form and any additional attachments to 210.704.2532.

To check on the status of this referral, call 210.704.4966, Monday – Friday, 8:00 a.m. – 4:30 p.m.

Date of Referral: _____

Contact for Referral:

Name: _____

Position: _____

Phone #: _____

Child's Top 5 Primary Diagnoses:

1. _____
2. _____
3. _____
4. _____
5. _____

Child's Pediatric Specialists (Name/Specialty/Frequency of Visits):

1. _____
2. _____
3. _____
4. _____
5. _____

Child's Information:

Child's Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female Preferred Language: _____

Primary Caregiver(s) Name(s): _____

Phone #: _____ Alt #: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care Physician:

Phone #: _____ Fax #: _____

Insurance: _____ Secondary Insurance: _____

How did you hear about us? _____

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Additional information:

Why do you feel a Complex Care program could be beneficial to the child?

- ☐ Coordination of appointments
- ☐ Frequent hospitalizations
- ☐ Difficulty with the complex medical plan
- ☐ Multiple health concerns
- ☐ Needs community and/or healthcare resources
- ☐ Other: _____

On average, how many medications does the child receive on a daily basis (oral, g-tube, inhaled, IV)?

- ☐ 0-3
- ☐ 3-6
- ☐ 6-10
- ☐ More than 10

Does the child have any medical equipment?

- ☐ Gastrostomy tube (G-tube)
- ☐ Gastrostomy-Jejunostomy tube (GJ-tube)
- ☐ Nasogastric tube (NG)
- ☐ Nasoduodenal tube (ND)
- ☐ Central Venous Line (CVL)/ Port (IVAD)
- ☐ Tracheostomy tube
- ☐ Ventilator
- ☐ BiPAP/CPAP
- ☐ VP Shunt
- ☐ TPN
- ☐ Oxygen
- ☐ Other: _____

Does the child have any of the following ancillary supports in place?

- ☐ Home health nursing
- ☐ DME supplies
- ☐ Therapies (e.g. Speech, OT, PT)

Please list any additional information you would like to provide:

Please feel free to include any attachments that you find would be helpful, for example:

- » **Medication List**
- » **Daily Schedule**
- » **Recent Labs**
- » **Well-Child Check**
- » **Specialist Notes**

Office Use Only:

Reviewed By: _____ Reviewed Date: _____

- ☐ Schedule Appointment:
  - Next available with: _____
  - Overbook (date/time): _____
  - Other: _____
- ☐ Referral Denied