Date of Referral: ____________________

Complex Care Medical Services

University of Texas Southwestern Medical Center at Dallas ● Children's Medical Center Dallas

Office: 469-488-7200 Fax: 469-488-7201

IMPORTANT NOTICE

All referral requests are reviewed weekly by the multi-disciplinary medical care team for acceptance into the program. Please fax this form and any additional attachments to 469-488-7201.
Please note, all requests are reviewed each Friday and we will contact you within one week.

① Indicate the reason for the Complex Chronic Care Medical Services appointment request:

❑ **Medical Home** ❑ **Care Coordination**

Please list the child's top 5 primary diagnoses:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Please provide the names of the child's pediatric specialists:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

② Please provide patient information:

Child's Name: LAST: ____________ FIRST: ____________ MIDDLE: ____________

DOB: ____/____/______ AGE: __________ SEX: M or F Primary Language: ______________

Parent(s) Names: ____________________

Address: Street ____________ City/State ____________ Zip Code ____________

Family Contact #'s: Home: ____________ Cell: ____________ Work: ____________

Primary Care Physician: ____________ Phone: ____________ Fax: ____________

Insurance: ____________ Secondary Insurance: ____________

How did you hear about us? : ____________________

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③ Additional Information:

Why do you feel Complex Care Medical Services 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: ____________________

Does the child have any medical equipment?

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

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

- ❑ 0-3
- ❑ 3-6
- ❑ 6-10
- ❑ More than 10

Please list any additional information you would like to provide:

____

____

____

● Please feel free to include any attachments that you find would be helpful●

● (i.e. medication list or MAR, daily schedule, lab results) ●

OFFICE USE ONLY **Reviewed by/date:** ____________________

❑ Schedule Appointment: ❑ Next Available with ______________ ❑ Overbook (Date/Time): ________________ ❑ Other: __________________

❑ Referral Denied