Patient Services Intake Form

Today's date (Day ______, Month ______________, Year ___________)

The International Patient Services Department will review this information and the child's medical records to recommend the best treatment plan for the child at The Children's Hospital of Philadelphia.

To help us better understand the patient's needs, please complete this form and return it with the documents listed on the checklist.

If you need assistance or have questions, our staff is here to help at 001-267-426-6298.

Next steps: What happens once we have received the child's completed forms and medical records?

1. An International Medicine Clinical Coordinator will review the medical records and discuss them with the appropriate clinical team at the Hospital.
2. After careful review, our physicians will determine if the patient can benefit from consultation and treatment at The Children's Hospital of Philadelphia. If so, we will provide a recommended treatment plan specific to the child's needs.
3. If the family would like to arrange to travel to The Children's Hospital of Philadelphia for care, we will discuss financial arrangements based on the patient's insurance or the family's preferred method of payment.
4. **Prior to any appointments being confirmed, financial clearance is required.** Payment of 100 percent of anticipated (estimated) services or confirmation of insurance must be received.

Patient Information

Name: ______________________________, ______________________________, ________
Last First MI

Date of Birth: _____, _________, _________ Age: _____ Gender: ○ Male ○ Female Citizenship: ___________________
Day Month Year

Permanent Residence Information

Address: ____
Street

______________________ ___________ ___________ ______________________
City State/Province Postal Code Country

Home Phone: ___________________________ Other Phone: ___________________________

Additional Information

What is the family's preferred spoken language? ___________________________________

Would you like us to provide an interpreter for the family during medical visits? ○ Yes ○ No

Spiritual Affiliation: ___________________________ Ethnicity: ___________________________

Do any special needs exist that we should be aware of? ___________________________________

Please tell us how you learned about International Patient Services at The Children's Hospital of Philadelphia:

○ Internet Search Engine
○ The Children's Hospital of Philadelphia's Website
○ External Physician
○ Physician from The Children's Hospital of Philadelphia
○ Family or Friend
○ Insurance Company
○ Embassy
○ Foundation
○ Employer
○ News/Media/TV
○ Other (please specify):
____
____
____

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Required Information

Parent 1 Information

Name: ______________________, ______________________, ______
Last First MI

Date of Birth: ____, ________, ________ Age: ____ Gender: ○ Male ○ Female Citizenship: ______________
Day Month Year

Cellphone: ______________________ Email Address: ______________________

Spoken Language(s): ______________________

Written Language(s): ______________________

Employer Information (Parent 1)

Name of Employer: ______________________ Phone: ______________

Address: ______________________
Street

______________ ________ ________ ______________
City State/Province Postal Code Country

Parent 2 Information

Name: ______________________, ______________________, ______
Last First MI

Date of Birth: ____, ________, ________ Age: ____ Gender: ○ Male ○ Female Citizenship: ______________
Day Month Year

Cellphone: ______________________ Email Address: ______________________

Spoken Language(s): ______________________

Written Language(s): ______________________

Employer Information (Parent 2)

Name of Employer: ______________________ Phone: ______________

Address: ______________________
Street

______________ ________ ________ ______________
City State/Province Postal Code Country

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Referring Physician Information

Please provide the name of the physician that has referred the patient to The Children's Hospital of Philadelphia.

Name: ______________________________, ______________________________, ______
Last First MI

Is the referring physician the same as the child's primary care physician?

○ Yes ○ No If no, please enter the child's primary care physician information below.

Name: ______________________________, ______________________________, ______
Last First MI

Referring Hospital/Organization Information

Name: ____

Address: ______________________________, ________________, ________________
Street City Country

Phone: ____________________________ Fax: ____________________________

Payment Information

Method(s) of Payment

○ Wire Transfer ○ Credit Card ○ Cash ○ Check ○ Bank Check

○ **Insurance** - Please provide us with the following information and attach copies of the front and back of all insurance cards:

Name of Insurance Plan: ________________________ Phone Number: ________________________

Claims Address: ________________________ ________________ ________ ________
Street City State/Province Postal Code

Subscriber's Name: ________________________, ________________________, ______
Last First MI

Subscriber's Date of Birth: _____, _________, _______ Policy Number: ____________ Group Number: ___________
Day Month Year

If your insurance is provided by your employer, please provide the following information:

Employer Name: ____________________ __________ ________________ ________________
City State/Province Country Phone

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Additional Medical Information

Patient's current diagnosis(es) (if known): ____________________

Has the child been diagnosed with health issues other than those you are seeking treatment for?

○ No ○ Yes (please specify): ____________________

____

Does the child eat by mouth? ○ No ○ Yes

Does the child receive supplemental feedings via nasogastric (NG) tube or gastrostomy tube (G tube)? ○ No ○ Yes

Does the child have an artificial airway (tracheostomy tube)? ○ No ○ Yes

Does the child receive supplemental oxygen? ○ No ○ Yes

Will there be a point of contact other than or in addition to Mom/Dad?

○ No ○ Yes **If yes,** please list the additional point of contact on the provided HIPAA release form.

Please list any specific medical questions you have regarding the child's condition/care, or questions you would like our specialists to answer:

Do you know what kind of specialist you would like the child to see? (It is OK if you do not have this information):

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Acceptance Checklist

All of the following documents (if available) are required in order to begin the review process.
Please use the column at right to indicate submitted items.

List of forms and supporting documentation	***Included?*** (Yes or No, Study Not Completed)	
1. Children's Hospital Patient Services Intake Form	○ Yes	
2. HIPAA (authorization to release/obtain patient information)	○ Yes	
3. Copies of insurance cards (if applicable)	○ Yes	
4. Most recent Physician Medical Summary	○ Yes	
5. Recent photograph of patient (full-length photo)	○ Yes	
6. Recent growth chart (height/weight)	○ Yes	
7. Medication list (name, amount and frequency)	○ Yes	
8. Specialist medical reports	○ Yes	○ No, Study Not Completed
9. Recent lab reports	○ Yes	○ No, Study Not Completed
10. Recent radiology reports	○ Yes	○ No, Study Not Completed
11. Radiology images (if available)	○ Yes	○ No, Study Not Completed
12. Recent pathology reports	○ Yes	○ No, Study Not Completed

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It is important that you follow all the guidelines listed above and send us the most complete, up-to-date information so we can respond promptly. Without the appropriate medical records, we unfortunately cannot review your request.

If you need assistance or have questions, our staff is here to help at 001-267-426-6298.