PHYSICIAN/CLINICIAN USE ONLY

Must request 3 or more appointments

Complex Scheduling at Children's Hospital of Philadelphia

Intake Form

Note: **Please complete all fields** and **attach medical history and/or summary of the last outpatient visit**.

Fax intake information to: 267-426-6292 (attn: Alice Alvarado, Nancy Tabarez, Nikita McCrea and Janet Mosley)

or send via email to: complexsched@email.chop.edu

Patient Name: ____________________________________DOB:________________MRN______________________

Parent/Guardian Name:_____________________________Contact Number :__________________________________

Insurance:____________________________ Member ID____

Primary Diagnosis:______________________Contact Name______________________Number:____________________

Referring Physician:________________________________ Physician Phone:______________________________

Current or Pending Discharge? (Please circle one If so, please include discharge summary)

Does the patient have specific medical needs, i.e. wheelchair? _____________________________________

Is this patient technology dependent?____

Is English the family's first language?____

If a translator is needed, what is the requested language?____

Required Appointments - Type and Time Frame: (In order of required sequence, if appropriate)

Division	Specific Physician	New or Follow-Up	Timeframe	Appt. Date (office use only)
1.				
Why is this specific department needed? What is the desired outcome?				
2.				
Why is this specific department needed? What is the desired outcome?				
3.				
Why is this specific department needed? What is the desired outcome?				
4.				
Why is this specific department needed? What is the desired outcome?				

Referring Physician/Clinician Signature:____ Date:_____________