Cook Children's
Dodson Specialty Building
1500 Cooper St, 3rd Floor
Fort Worth, TX 76104

Referral request

Complex Care Clinic
Heather Miller, MD
Samantha Reed, NP
682-303-6650 phone • 682-303-6667 fax
8:00 a.m. to 5:00 p.m., Mon-Fri

A clinic dedicated to the care of children with complex medical needs

We serve in either of the following two roles:

1) A transitional medical home for medically complex children who need access to a primary care physician (PCP) or need more intense support at critical times (such as after a hospital admission or acute change in health status).

OR

2) A consulting service to physicians whose patients may need assistance managing a complex plan of care.

Referral Criteria:

Birth to 21 years*

**New patients must be <17 at time of referral*

Resides in DFW area

One or more chronic conditions that cumulatively affect 3 or more organ systems and severely reduce their cognitive/physical functioning AND requires the use of medication, DME, therapy, surgery, or other treatments

OR

One life-limiting illness or rare pediatric disease

Exclusions: patients with a primary behavioral health diagnosis or those already receiving wraparound services through Cook Children's

Patient name: _____

Address: _____ Apt. # _____

City: _____ State: _____ ZIP: _____

SS #: _____ DOB: _____ Home phone #: _____

Primary language: _____ Cell phone #: _____

Insurance: _____ Policy holder: _____ DOB: _____

Insurance #: _____ ID #: _____ Group #: _____

2nd Ins: _____ Insured: _____ DOB: _____ ID/Group: _____

Referring physician: _____

Referring physician phone #: _____ Fax #: _____

***** Please FAX a copy of the patient's insurance card(s) to 682-303-6667 *****

Services requested:

- ◯ Consultation
- ◯ Transfer of Primary Care
- ◯ Ancillary Services (Case Management, Nutrition, Social Work, etc.)
- ◯ Other Services, please specify:

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Patient's Primary Diagnoses:

_____

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Medical Information

What concerns are you hoping to address with this referral?

- ◯ Coordination of appointments
- ◯ Frequent hospitalizations
- ◯ Difficulty with complex medical plan
- ◯ Multiple health concerns
- ◯ Community and/or healthcare resources
- ◯ Adult Transitions
- ◯ Other, please specify:

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Services receiving:

- ◯ Physical Therapy
- ◯ Occupational Therapy
- ◯ Speech Therapy
- ◯ Feeding Therapy
- ◯ Home Health Nursing
- ◯ Other, please specify:

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Current Specialties:

- ◯ Cardiology
- ◯ Dermatology
- ◯ Ear, Nose, Throat (ENT)
- ◯ Endocrinology
- ◯ Gastroenterology
- ◯ Genetics
- ◯ Hematology/Oncology
- ◯ Immunology
- ◯ Nephrology
- ◯ Neurology
- ◯ Orthopedics
- ◯ Palliative Care
- ◯ Pulmonology
- ◯ Rheumatology
- ◯ Sleep Medicine
- ◯ Urology

Medical Equipment:

- ◯ Feeding tube (i.e. g-tube, g-j tube, NG tube)
- ◯ Central venous line/port
- ◯ Total parental nutrition (TPN)
- ◯ VP shunt
- ◯ Wheelchair
- ◯ Tracheostomy
- ◯ Ventilator
- ◯ BiPAP/CPAP
- ◯ Oxygen
- ◯ Other, please specify:

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Please list or attach any additional information you would like to submit for consideration:

_____

_____

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Please fax this form, along with patient pertinent medical records and a copy of the patient's insurance card to **682-303-6667**.

Referrals are typically processed within 10 business days. If you have any questions or would like a referral status update, please contact the Cook Children's Complex Care Clinic at **682-303-6650**.

For office use only:

Date/time of appointment: _____ **Appointment made by:** _____