

International Intake Form



Website: <http://www.childrens.com>

Phone: 214-456-0670

Email: CHSTinternationalprogram@childrens.com

Mail: Children's Health, Attn: Managed Care, 1935 Medical District Drive, Dallas, TX 75235, USA

Children's HealthSM welcomes international patients yet Children's Health is not able to donate care to either international patients or sponsoring organizations bringing children to the U.S. for medical care. The care for most international patients is the responsibility of the patient's family including local lodging, food, and transportation expenses.

Please complete this form and return it with the medical records (translated into English) and supporting documents listed below. Once the form and records have been received, we will have the records reviewed by one of our specialists to provide an opinion. To provide the best care for your child, we will carefully review your child's medical records to choose the best treatment and care. If you need assistance or have any questions, our staff is here to help. See contact information above.

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: _____ Alternate 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 our facility:

Internet Search Engine

Physician from Children's Health System of Texas

Embassy

News/Media/TV

The Children's Health System of Texas Website

Family or Friend

Foundation

Other (Please specify): _____

External Physician

Insurance Company

Employer

International Intake Form

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

International Intake Form



Referring Physician Information

Please provide the name of the physician that has referred the patient to Children's Health System of Texas.

Name: _____, _____, _____
Last First MI

Is this 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/Providence Postal Code

Subscriber's Name: _____, _____, _____
Last First MI

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

Employer Name: _____ Phone Number: _____

Employer Address: _____, _____, _____, _____
Street City State/Providence Country

International Intake Form

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 (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):

International Intake Form

Acceptance Checklist

All the following documents (if available) are required to begin the review process.

Please use the column at right to indicate submitted items.

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

Do you need assistance with any of the following?

Transportation to and from airport: _____ Family size: _____

Information on surrounding hotels: _____ Other: _____

Information on surrounding restaurants: _____

Note: Patient's family is responsible for hotel, airfare, food, and local transportation expenses.

Next steps:

Once we have received the patient's completed intake form and medical record documentation:

1. An international coordinator will review the medical records and discuss them with the experts at our hospital.
2. After careful review, physicians on medical staff at Children's Health will determine if the patient can benefit from consultation and treatment at Children's Health. If so, we will provide a recommendation about the child's specific needs and proposed treatment plan.
3. If the family would like to arrange for care at Children's Health, we will discuss financial arrangements based on the patient's insurance or the family's preferred method of payment.
4. We will provide a letter confirming your treatment plan to assist with visa applications and will schedule the necessary appointments. Once appointment scheduling is confirmed, an appointment reminder is sent to the family.

Before appointments are confirmed, 100% of payment for anticipated services or confirmation of health insurance must be received.

International Intake Form



I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or other health care providers for my child and waive my right to informed consent of treatment. This waiver applies if neither parent/guardian can be reached in the case of an emergency. Any patient under 18 years of age who comes to the U.S. for medical treatment must be accompanied by an adult with legal authority to consent for care and treatment, including surgery if necessary.

Parent's/Guardian's Signature:

Date:

If you need assistance or have questions, our staff is here to help at 001-214-456-0670.