

APPLICATION FOR TREATMENT SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

To Be Completed By Parent or Guardian

*Name of Child					
*Last		*First		Middle	Suffix
*Application Date (Today's Date)	Child's SSN	*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
*DOB	Who does child live with? <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other (relationship) _____				
Primary Language		Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No			
*Home Address					
*Country		*Street Address			
*Zip Code	*City	*State	County		
Phone Primary /Home Number			Phone Alternate Number		
*Mailing Address (if different from home address)					
*Country		*Street Address			
*Zip Code	*City	*State	County		

Mother						
Last		First		Middle	Suffix	Maiden Name
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated						
Home Address (if different from patients)						
*Country		*Street Address				
*Zip Code	*City	*State	County			
Phone Primary /Home Number				Phone Alternate Number		

Father						
Last		First		Middle	Suffix	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated						
Home Address (if different from patients)						
*Country		*Street Address				
*Zip Code	*City	*State	County			
Phone Primary /Home Number				Phone Alternate Number		

Additional Relations						
Relationship to Patient						
Last		First		Middle	Suffix	
Home Address (if different from patients)						
*Country		*Street Address				
*Zip Code	*City	*State	County			
Phone Primary /Home Number				Phone Alternate Number		

APPLICATION FOR TREATMENT SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

Name of Child

To Be Completed By Parent or Guardian

Legal Guardian (if different from parent)			
Last	First	Middle	Suffix
Home Address (if different from patients)			
*Country		*Street Address	
*Zip Code	*City	*State	County
Phone Primary /Home Number		Phone Alternate Number	

Sponsoring Temple and Shriner	Temple			
Sponsoring Shriner Name	Last	First	Sponsor signature date	
Street Address	City	State	Zip Code	Country
Sponsoring Shriners Signature				
Needs Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No Ambulatory Status				

Medical				
*Problem or Diagnosis (What is your child's problem?)				
Onset <input type="checkbox"/> Before Birth <input type="checkbox"/> Developed Recently <input type="checkbox"/> Injury-Date Known Injury date _____				
<input type="checkbox"/> Injury-Date Unknown <input type="checkbox"/> Onset of walking <input type="checkbox"/> Since Birth Other				
Chief Complaint (Why do you want to be seen by the Shrine Hospital? What services are you looking for?)				
Referring Physician				
Street Address	City	State	Zip Code	Country
Previous treatments provided				
Treatments and Surgeries				
X-rays available? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Most Recent X-ray Date Last Seen by Physician				

Insurance/Primary		
Subscriber Name		
Health Plan		
Name	Subscriber Member Number	Patient Member Number
Primary Care Provider		

Supplemental Information					
Referral Source (Select One)					
<input type="checkbox"/> Billboard	<input type="checkbox"/> Bumper Sticker	<input type="checkbox"/> Family Member/Self	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other
<input type="checkbox"/> Poster/Flyer	<input type="checkbox"/> Physician	<input type="checkbox"/> Other Health Care Professional	<input type="checkbox"/> School Teacher	<input type="checkbox"/> School	<input type="checkbox"/> Radio
<input type="checkbox"/> Shriner	<input type="checkbox"/> Television	<input type="checkbox"/> Friend (non-Shriner)	<input type="checkbox"/> Watts Line	<input type="checkbox"/> Website	
Family Income for last 12 months					
<input type="checkbox"/> \$0 - \$10,000	<input type="checkbox"/> \$10,001 - \$20,000	<input type="checkbox"/> \$20,001 - \$30,000	<input type="checkbox"/> \$30,001 - \$40,000	<input type="checkbox"/> \$40,001 - \$50,000	
<input type="checkbox"/> Over \$50,000	<input type="checkbox"/> Not provided				

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SHRINERS HOSPITALS FOR CHILDREN**

***Required Information**

Name of Child _____

FOR HOSPITAL USE ONLY				
Application Status				
COS Recommendation	<input type="checkbox"/> Accept	<input type="checkbox"/> Reject	<input type="checkbox"/> Screen	Date of Recommendation
COS Comments				
BOG Recommendation	<input type="checkbox"/> Application Expired	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Date of Recommendation
Primary Shrine Physician			Care Coordinator	
COS Signature				
BOG Signature				
Service Line	<input type="checkbox"/> Ortho	<input type="checkbox"/> Burn	<input type="checkbox"/> SCI	<input type="checkbox"/> Plastic
Over Age Patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Expedite (indicate specific timeframe if applicable)				