Advocate Children's Hospital

Coordinated Care for Children with Medical Complexity

Please fax completed forms to CCCMC Program: 708.684.4717

Referred by: _____ Contact number: _____

Date of referral: _____

Are you the patient's primary care provider? Yes No

If not the PCP: What is your relation to the patient? _____

Has the PCP been notified of this referral: Yes No Date notified: _____/_____/_____

Are they in agreement with referral to CCCMC program? Yes No

Office contact for PCP: _____ Phone: _____

Before completing this form, please answer the following:

- Does the patient live within 25 miles of the Advocate Children's Hospital Oak Lawn Campus? (If not, consultation rather than primary care will be available)
- Does the patient have at least 3 body systems involved that contribute to their medical complexity?*
- Does the patient have dependency on at least one technological device? (i.e. GTube, Trach, Vent, etc.)**
- Does the patient have severe neuromotor compromise or severe developmental delay?
- Does the patient currently see another inter-professional clinic? (i.e. CF, Cardioneurodevelopmental, etc.)
  If yes, please list here: _____

Please list conditions/diagnosis that prompted this referral with onset date if known:

If less than 3 body systems involved – this patient does NOT meet criteria for acceptance into the CCCMC program

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any technology that this patient uses: (i.e. Gtube, vent dependent, port-a-cath, etc.)

****If patient does not require any technology support - this patient does NOT meet criteria for acceptance into the CCCMC Program***

_____

_____

_____

_____

CCCMC Program | 4440 W. 95th Street, Suite 1200H, Oak Lawn, IL 60453 | P: 708.684.1399 | F: 708.684.4717
pedscomplexcare@advocatehealth.com | www.advocatechildrenshospital.com/ach/CCCMC

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Please describe any severe neuromotor compromise or developmental delay below:

_____

_____

_____

_____

Reason for referral:

- ○ Care coordination
- ○ Adherence problems
- ○ Frequent ER visits/hospitalizations
- ○ Social Issues
- ○ Multiple systems involved
- ○ Needs resources
- ○ Other _____

Patient's name (Last, First, M) _____, _____, _____

Parent/Guardian Name: _____

DOB _____/_____/_____ Age _____ Male Female

Street Address _____

City _____State _____ Zip code _____

Home phone _____ Cell phone _____

Insurance name _____ID# _____

FOR OFFICE USE ONLY Referral approved: Yes No Appt. scheduled for intake: _____/_____/_____ Time: _____	Comments:
Intake completed: _____/_____/_____ Time:	Completed by: _____
Office visit scheduled: _____/_____/_____	Records received: ____/_____/_____
Team notified: _____/_____/_____	Referring office/person notified:

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