



The Children's Hospital of Philadelphia®
INTERNATIONAL MEDICINE

Patient Services Intake Form

The International Patient Services Department will review this information and the child's medical records to recommend the best treatment plan for the child at The Children's Hospital of Philadelphia. To help us more fully understand the patient's needs, please complete this form and return it with the documents listed below. If you need assistance or have questions, our staff is here to help at 001-267-426-6298.

Please tell us who is referring the patient to The Children's Hospital of Philadelphia (child's primary care doctor/specialist)

Today's date	(dd/mm/yy) (__/__/__)		
Referring physician's name:			
	Last	First	MI
Address	City		Country
Email	Phone	Fax	

All of the following documents are required (if they are available) in order to begin the review process. Please indicate in the column at right which items you have included, so we know when your information is complete and ready for clinical review.

<i>List of forms and documentation</i>	<i>Included?</i> (Yes, or No Study Not Completed)
1. Children's Hospital Patient Services Intake Form	
2. HIPAA form	
3. Specialist medical reports	
4. Most recent history and physical	
5. Recent lab reports	
6. Recent radiology reports	
7. Were radiology films sent?	
8. Recent pathology reports	
9. Were slides sent?	

It is important that you follow all the guidelines listed above and send us the most complete, up-to-date information so that we can respond promptly. Without medical records, we cannot review your request.



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Next steps: What happens once we have received the child's completed intake form and medical record documentation?

1. An International Clinical Manager will review the medical records and discuss them with appropriate clinicians at the Hospital.
2. After careful review, our physicians will determine if the patient can benefit from consultation and treatment at Children's Hospital. 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 The Children's Hospital of Philadelphia, we will discuss financial arrangements based on the patient's insurance or the family's preferred method of payment.
4. We will provide documentation confirming a treatment plan to embassies to assist with visa applications and begin to schedule the necessary appointment(s) for the child at Children's Hospital.

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

Once appointment scheduling is confirmed, a personalized itinerary is sent to the family. Our staff will also offer Concierge services to make the family's travel and stay in Philadelphia as smooth as possible.



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Required Patient Information				
Patient Information:	Last	First	MI	
Date of Birth (MM/DD/YY)	Age	Gender	Citizenship	
Parent Information:	Last	First	MI	DOB(MM/DD/YY)
Parent Information:	Last	First	MI	DOB(MM/DD/YY)
Permanent Home Address	City	State	Zip	Country
Email	Phone	Cell Phone		
Temporary Address (in US)	City	State	Zip	
Temporary Phone				
Parent/Guardian Employment Information				
Name of Employer	Telephone Number		Occupation	
Address	City	State	Zip	Country
Other Information				
Spoken Languages	Written Languages	Which is Preferred?		
Do you require an interpreter during medical visits?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	
What is your family's preferred language?				
Additional Information				
Spiritual Affiliation	Ethnicity	Any special needs we should be aware of?		



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Additional Medical Information

Please tell us any specific medical questions you have regarding the child's condition/care, or what 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)

Patient's current diagnosis(es) (if known)



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Payment Information

Method of Payment

Cash Wire Transfer Check Bank Check

Mastercard Visa American Express

International Insurance If you have insurance, it is important that you provide us with the following information:

Name of the Cardholder

Date of birth of the Card Holder

Policy Number

Subscribers Name (Last, First Middle)

Insurance Company Address

City, State, ZIP

Telephone Number

If insurance is through your employer, please provide following information:

Employer name

Address

Telephone Number

Name of insurance plan

Policy Number

Subscribers Name (Last, First Middle)

Insurance Company Address

City, State, ZIP

Telephone Number

Please attach copies of the front and back of the insurance cards.



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Support Services Requested

Please indicate if the patient or family requires assistance with any of the following:

YES

NO

	YES	NO
1. Accommodations (if yes, indicate price range:)	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the family interested in touring our hospital?	<input type="checkbox"/>	<input type="checkbox"/>
3. Information on Philadelphia?	<input type="checkbox"/>	<input type="checkbox"/>
4. Transportation options available to them? (for example, from airport, to hospital, car rental, etc)	<input type="checkbox"/>	<input type="checkbox"/>
5. Banking	<input type="checkbox"/>	<input type="checkbox"/>
6. Religious Organizations	<input type="checkbox"/>	<input type="checkbox"/>
7. Interpretation Services (outside of the hospital)	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate any special needs/requests the patient might have (attach additional page as needed):

Please tell us how you learned about The Children's Hospital of Philadelphia?

1. Internet	<input type="checkbox"/>
2. Children's Hospital Web site	<input type="checkbox"/>
3. Embassy	<input type="checkbox"/>
4. Physician	<input type="checkbox"/>
5. Advertisement	<input type="checkbox"/>
6. Personal Contact	<input type="checkbox"/>
7. Other (please tell us)	<input type="checkbox"/>