PHYSICIAN/CLINICIAN USE ONLY

Must request 3 or more appointments

Complex Scheduling at The Children's Hospital of Philadelphia

Intake Form

Note: **Please complete all fields** and **attach medical history and/or summary of the last outpatient visit**.
Fax intake information to: 267-426-6292 or send via email to: complexsched@email.chop.edu

Patient Name: _____DOB:_____MRN_____

Parent/Guardian Name:_____Contact Number :_____

Insurance:_____ Member ID_____

Primary Diagnosis:_____Contact Name_____Number:_____

Referring Physician:_____ Physician Phone:_____

Current or Pending Discharge? (Please circle one If so, please include discharge summary)

Does the patient have specific medical needs, i.e. wheelchair? _____
Is this patient technology dependent?_____
Is English the family's first language?_____
If a translator is needed, what is the requested language?_____

Required Appointments- Type and Time Frame: (In order of required sequence, if appropriate)

Division	Specific Physician	New or Follow-Up	Timeframe	Appt. Date (office use only)
1.				
Why is this specific department needed? What is the desired outcome?				
2.				
Why is this specific department needed? What is the desired outcome?				
3.				
Why is this specific department needed? What is the desired outcome?				
4.				
Why is this specific department needed? What is the desired outcome?				

Referring Physician/Clinician Signature:_____ Date:_____