Complex Care Program Referral Form

Arkansas Children's Hospital
1 Children's Way, Slot 855-B
Little Rock, AR 72202
Office phone: 501-364-3030
Office Fax: 501-364-3484

Referral Criteria: ***(patient must meet at least one of three items listed)***

1. **Child has at least two medically complex conditions and is being followed by at least two pediatric subspecialist: Yes _____ No _____**
2. **Child has at least two of the following (please indicate the conditions): Yes _____ No _____**
   - **Dependent on special medical technology, i.e. G-tube or other tube feedings, oxygen/other respiratory support needed _____**
   - **Born with extremely low birth weight and preterm <=1250 grams, <=32 weeks gestation _____**
   - **Congenital syndrome/anomalies/disease or chromosome abnormality _____**
   - **Significant neurodevelopmental disabilities _____**
3. **Child's mother tested positive for the ZIKA virus during pregnancy referring for surveillance and care if needed _____**

Prior to initial visit to the complex care clinic we must have:
Documented CO-authority agreement between the Complex Care Clinic and the child's assigned PCP for all Medicaid patients.

Referral source/Name Phone number:

_____

PCP: _____Phone:_____

PCP address: _____ City _____

Zip: _____ Phone: _____ Fax _____

Arkansas Children's
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Patient Name_____ DOB _____

ACH# - (If Applicable) _____

Parent/Caregiver Name _____

Patient Address _____

City_____ State _____ Zip _____

Phone#_____Cell#_____Message#_____

Reason for Referral: (What can our program do for this patient?)

_____

_____

_____

_____

Subspecialty Services:

_____

_____

Please include the following information with this referral:

- **Medicaid number included on referral for PCP co-authority**
- **Insurance information**
- **Documentation of weights, lengths, and head circumference**
- **Documentation of well child check-ups**
- **Any additional medical documentation**