Arkansas Children's

Complex Care Program Referral Form

Arkansas Children's Hospital
1 Children's Way, Slot
Little Rock, AR 72202
Office phone: 501- 364-3030
Office Fax: 501-364-4264

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 ☐ Click here to enter text.
   - Born with extremely low birth weight and preterm <=1250 grams, <=32 weeks gestation ☐ Click here to enter text.
   - Congenital syndrome/anomalies/disease or chromosome abnormality ☐ Click here to enter text.
   - Significant neurodevelopmental disabilities ☐ Click here to enter text.
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 Click here to enter text. **PCP** Click here to enter text.

PCP address: Click here to enter text. **City** Click here to enter text.

Zip: Click here to enter text. **Phone:** Click here to enter text. **Fax** Click here to enter text.

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Patient Name: Click here to enter text. **DOB:** Click here to enter text.

ACH# (If Applicable) Click here to enter text.

Parent/Caregiver Name: Click here to enter text.

Patient Address: Click here to enter text.

City Click here to enter text. **State** Click here to enter text. **Zip** Click here to enter text.

Phone#Click here to enter text. **Cell#**Click here to enter text. **Message#**Click here to enter text.

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

Click here to enter text.

Subspecialty Services:

Click here to enter text.

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