

## **Patient and Physician Referral Form**

### **HOW TO REQUEST ASSISTANCE**

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The patient referral form serves as the primary source of information in requesting assistance and evaluating the request. Please be as complete as possible and be certain all information is included on/with the form. **Completion of this form does not guarantee assistance.** There are specific medical areas, or types of equipment the program is incapable of funding. We reserve the right to seek additional information from the applicant, the child's physician(s), and any other charity or government program involved with the child or from the proposed service/equipment suppliers. We reserve the right to seek additional price quotes from other suppliers of equipment or services

### **INSTRUCTIONS**

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1. **Patients Physician** – Full complete name along with address. We Must have this in order to contact doctor when further medical information is needed.
2. **Family information** - including phone numbers.
3. **Combined income** – Since our program is based upon need, we must be able to assess the financial situation. Requests without income information will be returned.
4. **Hospital/health insurance** – We require all insurance benefits to be applied first before we provide assistance. Most union covered workers do have health insurance, but it is called a pension and benefit plan.
5. **Patient's physical disability and needs** – Childs primary physician must complete "Physician Use Only" section providing basic problem and recommendation for treatment. While we want as complete information as possible, we concentrate upon what specifically needs to be done to help the child. We do not issue blanket approvals for unlimited treatment. We are best suited to handle a specific request for a piece of equipment (i.e. shoes, wheelchair), service (physical therapy), or a defined program of treatment (exercises).

Whenever possible, cost estimates, names and address of providers, and specific models or types of equipment should be included. Submit all support information with application. Failure to provide specifics of requested assistance will only delay the processing time.

### **ILLINOIS ELKS CHILDREN'S CARE PROGRAM REFERRAL FORM FOR ASSISTANCE**

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IF YOU KNOW OF A CHILD IN NEED OF OUR ASSISTANCE, PLEASE PROVIDE THE FAMILY WITH THIS PATIENT REFERRAL FORM. COMPLETED APPLICATION AND DOCUMENTATION SHOULD BE SUBMITTED TO ADDRESS ON FORM

IF YOU HAVE ANY QUESTIONS YOU MAY CALL OUR TOLL FREE NUMBER 1- 800-272-0074

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The Illinois Elks Children's Care Program is centered in the orthopaedic field. We have sponsored free orthopaedic clinics and services for physically challenged children for many years. Information about a clinic in your area may be obtained by calling the toll free number.

The Illinois Elks Children's Care Program is designed to help children with physical challenges which limit their participation in life to its fullest. We are dedicated to providing those services which will enable any child to achieve his/her maximum potential, while growing to adulthood as free as possible from physical limitations.

# Patient and Physician Referral Form

ILLINOIS ELKS  
CHILDREN'S CARE CORPORATION  
1201 N MAIN - PO BOX 222 - CHATHAM, IL 62629-0222

CLINIC AT \_\_\_\_\_

SPONSORING LODGE \_\_\_\_\_

PATIENT'S PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ (ZIP) \_\_\_\_\_

NEW \_\_\_\_\_

PATIENT REFERRAL FORM

RETURN \_\_\_\_\_

DATE \_\_\_\_\_

PATIENT'S

NAME \_\_\_\_\_

(Last)

(First)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ RACE \_\_\_\_\_

MARITAL STATUS: S = Single M = Married D = Divorced CIRCLE ONE BY EACH PARENT

FATHER \_\_\_\_\_ AGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_ PHONE \_\_\_\_\_

[S] [M] [D]

MOTHER \_\_\_\_\_ AGE \_\_\_\_\_ OCCUPATION \_\_\_\_\_ PHONE \_\_\_\_\_

[S] [M] [D]

GUARDIAN \_\_\_\_\_

PHONE \_\_\_\_\_

MONTHLY INCOME \_\_\_\_\_ RECEIVING PUBLIC AID \_\_\_\_\_

PRIVATE / GROUP INSURANCE: YES \_\_\_\_\_ NO \_\_\_\_\_ STATE MEDICAL CARD: YES \_\_\_\_\_ NO \_\_\_\_\_ KID CARE: YES \_\_\_\_\_ NO \_\_\_\_\_

OTHER CHILDREN & AGES \_\_\_\_\_

TYPE OF BIRTH (Cesarean/Normal) \_\_\_\_\_ (Length of Labor) \_\_\_\_\_

WHY IS THIS CHILD HERE TODAY \_\_\_\_\_

IS THIS CHILD UNDER THE CARE OF ANY STATE AGENCY OR OTHER CHARITY? \_\_\_\_\_

NAME OF CHARITY OR STATE AGENCY \_\_\_\_\_

I HEREBY GIVE CONSENT FOR THE EXAMINATION AND DIAGNOSTIC STUDIES PERFORMED ON MY CHILD AT THE ELKS CLINIC AND HAVE READ THE WAIVER, RELEASE AND CONSENT AGREEMENT ON THE REVERSE SIDE AND CONCUR WITH ITS CONDITIONS.

SIGNATURE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

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PHYSICAL EXAMINATION / DIAGNOSIS \_\_\_\_\_

RECOMMENDATION \_\_\_\_\_

SIGNATURE OF PHYSICIAN \_\_\_\_\_ DATE \_\_\_\_\_