SickKids®

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

International Patient Program

Referral Form

Please complete this form in ENGLISH only.
Sections 1 to 7 must be completed IN FULL and signed by the patient's Parent/Legal Guardian.

SECTION 1: PATIENT INFORMATION			
Last Name	First Name	Middle Name	
Date of Birth (DD-MM-YYYY)	Country of Birth	Country of Citizenship	
Gender ☐ Male ☐ Female ☐ Other	Language(s) Spoken at Home	English Interpreter Needed? ☐ Yes ☐ No	
Home Address			
City	Province/State	Country	Postal Code/Zip Code
Home Phone	Email Address		
Diagnosis	Comments on Patient's Condition		
Purpose of Referral ☐ Telehealth Consultation ☐ Medical Second Opinion ☐ Assessment/Consultation ☐ Medical/Surgical Treatment	Method of payment for healthcare services at The Hospital for Sick Children ☐ Insurance ☐ Self-Pay ☐ Embassy or Third Party Organization ☐ Applying for assistance through the Herbie Fund		

SECTION 2: PARENT/LEGAL GUARDIAN INFORMATION			
Name of Parent/Legal Guardian 1	Relationship to Patient (e.g. Parent)	E-mail Address	
Home Phone	Mobile Phone	Work Phone	
Name of Parent/Legal Guardian 2	Relationship to Patient (e.g. Parent)	E-mail Address	
Home Phone	Mobile Phone	Work Phone	
Who is the primary contact for this patient? ☐ Parent/Legal Guardian 1 ☐ Parent/Legal Guardian 2 ☐ Other (Please Specify)			
Home Address of Primary Contact ☐ Same as Patient Address			
City	Province/State	Country	Postal Code/Zip Code
Home Phone	Email Address		

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SECTION 3: FINANCIAL BACKGROUND INFORMATION

The Hospital for Sick Children reserves the right to request any of the following financial documentation as part of the application/referral process:

- A letter from the employer(s) confirming employment and annual salary for the employed parent(s)
- Copies of income tax filings for the past two (2) years
- Statements verifying bank account balances

Parent/Legal Guardian 1 Occupation	How Long in Current Position
Employer Company Name of Parent/Legal Guardian 1	Parent/Legal Guardian 1 Employer Contact Name and Telephone #
Parent/Legal Guardian 2 Occupation	How Long in Current Position
Employer Company Name of Parent/Legal Guardian 2	Parent/Legal Guardian 2 Employer Contact Name and Telephone #
Principal Income Earner? ☐ Father ☐ Mother ☐ Other (Please specify)	
Family's Annual Income in $USD	Number of Dependents in Family

SECTION 4: PAYMENT INFORMATION

Please indicate who will be financially responsible for payment. Check the appropriate box and provide all details.

☐ Insurance	Name of Insurance Company	Policy Holder	
Policy Number	Group Number	Maximum Coverage Amount in $USD	
Business Address			
City	Province/State	Country	Postal Code/Zip Code
Third Party Administrator (if applicable)	Telephone		

☐ Self-Pay (Please provide information on the person who will be financially responsible for payment.)

Last Name	First Name	Initial	Relationship to Patient
Home Address			
City	Province/State	Country	Postal Code/Zip Code
Telephone #	Fax #	E-mail Address	

☐ Embassy or Third Party Organization (Written guarantee of responsibility for payment will be required.)

Name of Embassy or Third Party Organization and Key Contact Information			
Business Address			
City	Province/State	Country	Postal Code/Zip Code
Telephone #	Fax #	E-mail Address	

☐ This is an application for Herbie Funding Assistance

NOTE: The Herbie Fund assists children from developing countries to receive surgical treatment, which is not readily available in their home region, at The Hospital for Sick Children. The Herbie Fund has specific criteria and guidelines for surgical treatments that are eligible for funding, and will cover **ONLY THE MEDICAL COSTS** for those treatments who meet the required criteria. All other costs (e.g. travel, accommodation for family, living costs while in Toronto, etc.) are the responsibility of the family.

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SECTION 5: CANADIAN CONTACT INFORMATION

Do you have a Canadian contact?
☐ Yes (If yes, please provide details below) ☐ No

Contact Name		Relationship to Patient
Home Address		City
Province	Country	Postal Code/Zip Code
Home Phone	Mobile Phone	E-mail Address

SECTION 6: TRAVEL INFORMATION

How will non-medical expenses (e.g. travel, accommodation, daily living expenses, etc.) be paid?

SECTION 7: PARENT/LEGAL GUARDIAN AGREEMENT AND SIGNATURES

The International Patient Program recommends all medical documentation (e.g. medical reports, scans, X-rays, echo tapes, etc.) be photocopied prior to submitting to The Hospital for Sick Children. If original medical records are submitted, The Hospital for Sick Children is not liable for their loss or damage, or for costs incurred to replace the submitted medical records.

Please check appropriate box below.
☐ I am submitting original medical documentation.
☐ I am submitting photocopied medical documentation.

Please print and sign the agreement below.

CONFIRMATION OF AGREEMENT

By signing below, I hereby certify that all information provided and enclosed is true and correct, and submit the medical documentation in full agreement of the above stated terms. Any application containing false information will be considered to be null and void.
I agree that upon my child receiving medical clearance from the SickKids medical team, it is expected that we will return to our home country/place of residence abroad.

_____	_____	_____
Printed Name of Parent/Legal Guardian	Parent/Legal Guardian Signature	Date (DD-MM-YYYY)

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Sections 8 to 11 must be COMPLETED IN FULL and SIGNED by the **patient's referring physician**.

SECTION 8: REFERRING PHYSICIAN INFORMATION			
Name of Referring Physician		Specialty	
Name of Referring Hospital		Address of Referring Hospital	
City	Province/State	Country	Postal Code/Zip Code
Telephone #		Fax #	E-mail Address

The Hospital for Sick Children requires that the patient's referring physician provide documentation to verify that the required assessment, procedure, surgery, treatment and/or specialized medical expertise is not available in the patient's home country or region.

SECTION 9: MEDICAL SUMMARY

Please state clinical history and submit all relevant medical information, including: up-to-date **(within past 6 months)** medical history, diagnosis, height, weight, allergies, vaccinations, results of tests/procedures, medications, and current symptoms. (If the space below is insufficient, please feel free to attach documents). **The International Patient Program is unable to accept any supporting medical records obtained more than 6 months prior to submission of this referral to The Hospital for Sick Children.**

How long has the patient been under your care?

What is the patient's primary and/or secondary clinical diagnosis?

Are there underlying medical conditions to the primary and/or secondary clinical diagnosis?

What assessment/treatment is being sought for this patient?

What is the reason for referral abroad?

What is the urgency of required assessment/treatment? ☐ 1 - 3 months ☐ 4 - 6 months ☐ 6 - 12 months

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SECTION 10: COORDINATION OF POST OPERATIVE/FOLLOW UP CARE

Is post-operative and/or ongoing follow-up care available and accessible in this patient's home country?

☐ Yes ☐ No

If no, please indicate if the patient will be able to receive post-operative and/or ongoing follow-up care in a neighboring country or region, and provide details.

SECTION 11: REFERRING PHYSICIAN AGREEMENT AND SIGNATURE

All international patient referrals must have a responsible physician in the patient's home region who will ensure ongoing care and follow-up once the child is discharged from The Hospital for Sick Children.

CONFIRMATION OF AGREEMENT

By signing below, I am accepting responsibility for

(a) providing evidence that all, or a key portion of the required treatment cannot be performed in the Patient's country of residence or home region, or is not reasonably accessible to the patient;

(b) providing to SickKids an accurate, complete, and current description of Patient's condition, including any change in condition from that provided for cost estimate, up to the point of departure from the patient's country of residence;

(c) providing or arranging the provision of all post-medical treatment/post-operative and follow up care in a neighbouring country or home region to the patient's home country transfer of care from The Hospital for Sick Children.

Print Name of Physician	Physician Signature	Date (DD-MM-YYYY)	Time (00:00)

Physician Stamp/Seal