SickKids

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

FOR HOSPITAL STAFF TO ENTER DATA OR AFFIX LABEL

# 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<br>☐ Virtual Consultation<br>☐ Assessment/Consultation<br>☐ Medical/Surgical Treatment | Method of payment for healthcare services at The Hospital for Sick Children<br>☐ Insurance<br>☐ Self-Pay<br>☐ Embassy or Third Party Organization<br>☐ 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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| | |
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# International Patient Program

# Referral Form

## 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.

SickKids

LAST NAME (FIRST)

MRN VISIT NUMBER

DATE OF BIRTH SEX
DD-MM-YYYY

ADDRESS

FOR HOSPITAL STAFF TO ENTER DATA OR AFFIX LABEL

# International Patient Program

# Referral Form

## 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 and submitting the medical documentation, I hereby certify that all information provided and enclosed is true and accurate, and I agree to the terms set out in this application. I acknowledge that providing false information, falsifying supporting documents or evidence, omitting relevant information, or making false statements in or with respect to the application is grounds for the International Patient Program to deny or rescind the eligibility of my child for care at The Hospital for Sick Children.**

**I agree that upon my child receiving medical clearance from The Hospital for Sick Children 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) |
|---|---|---|
| | | |

SickKids®

LAST NAME (FIRST)

MRN VISIT NUMBER

DATE OF BIRTH DD-MM-YYYY SEX

ADDRESS

FOR HOSPITAL STAFF TO ENTER DATA OR AFFIX LABEL

# International Patient Program

# Referral Form

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

SickKids®

# International Patient Program

# Referral Form

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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.

I acknowledge that providing false information, falsifying supporting documents or evidence, omitting relevant information, or making false statements in or with respect to this application is grounds for the International Patient Program to deny or rescind eligibility of the patient for services at The Hospital for Sick Children and to refuse other applications I make in support of my patients.

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

Physician Stamp/Seal