Driscoll Children's Hospital

High Risk Follow-Up Program Referral Form

Section A: High Risk Follow-Up (HRF) Program Registration Information

Patient's Name: _____ DOB: _____

Guardian's Name: _____

Address: _____

Home Phone Number: _____

Pertinent Diagnosis: _____

Discharging Neonatal Intensive Care Unit: (If Applicable) _____

Section B: Medical Eligibility Criteria Met For HRF Program

Birth weight: _____ grams Gestational age at birth: _____ weeks, _____ days

PLEASE CHECK ALL THAT APPLY:

- ☐ **≤ 1500 grams**
- ☐ **≤ 32 weeks, 0 days**
- ☐ **Total body cooling**
- ☐ **ECMO**
- ☐ **Cardiac disease**
- ☐ **Documented seizures**
- ☐ **Neurologic Abnormality**
- ☐ **PVL**
- ☐ **IVH grade:** _____

Section C: Referral Process Check List

PLEASE PROVIDE THE FOLLOWING DOCUMENTS AND FAX TO APPROPRIATE OFFICE (SEE BELOW)

- ☐ **Patient face sheet**
- ☐ **Hospital discharge summary**

Section D: Referring Practice Information

Referring Provider Name: _____

Practice Name: _____ Practice #: _____

Address: _____ Telephone: _____ Fax: _____

Physician Signature: _____ Date: _____

If you have any questions, please to do not hesitate to contact us.

High Risk Follow-Up Program
3533 S. Alameda St.
Corpus Christi, TX 78411
Office: (361) 694-5461
Fax: (361) 808-2179

High Risk Follow-Up Program
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Harlingen, TX 78550
Office: (956) 698-8650
Fax: (956) 698-8655

High Risk Follow-Up Program
10710 McPherson Rd. #202
Laredo, TX 78041
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Fax: (956) 718-4022

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