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 do not hesitate to contact us.

Corpus Christi
3533 S. Alameda St., Corpus Christi, TX 78411
Office: (361) 694-5461 | Fax: (361) 808-2179

Harlingen
2121 Pease St., Medical Arts Pavilion, Ste 601, Harlingen, TX 78550
Office: (956) 698-8650 | Fax: (956) 698-8655

Edinburg
2820 W. Michelangelo Dr., Edinburg, TX 78539
Office: (956) 217-3410 | Fax: (956) 688-3006

Laredo
10710 McPherson Rd., Ste 202, Laredo, TX 78041
Office: (956) 794-8450 | Fax: (956) 718-4022

September 2024