APPLICATION FOR TREATMENT
SHRINERS HOSPITALS FOR CHILDREN

***Required Information**

To Be Completed By Parent or Guardian

***Name of Child**			
*Last	*First	Middle	Suffix
*Application Date (Today's Date)	Child's SSN	*Gender ☐ Male ☐ Female ☐ Other ☐ Unknown	
*DOB	Who does child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other (relationship) _____		
Primary Language	Interpreter Required ☐ Yes ☐ No		
***Home Address**			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		
***Mailing Address (if different from home address)**			
*Country	*Street Address		
*Zip Code	*City	*State	County

Mother				
Last	First	Middle	Suffix	Maiden Name
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated				
Home Address (if different from patients)				
*Country	*Street Address			
*Zip Code	*City	*State	County	
Phone Primary /Home Number	Phone Alternate Number			

Father			
Last	First	Middle	Suffix
Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated			
Home Address (if different from patients)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

Additional Relations			
Relationship to Patient			
Last	First	Middle	Suffix
Home Address (if different from patients)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

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*Required Information

Name of Child **To Be Completed By Parent or Guardian**

Legal Guardian (if different from parent)			
Last	First	Middle	Suffix
Home Address (if different from patients)			
*Country	*Street Address		
*Zip Code	*City	*State	County
Phone Primary /Home Number	Phone Alternate Number		

Sponsoring Temple and Shriner	Temple		
Sponsoring Shriner Name	Last	First	Sponsor signature date
Street Address	City	State	Zip Code	Country
Sponsoring Shriners Signature			
Needs Transportation ☐ Yes ☐ No	Ambulatory Status		

Medical				
*Problem or Diagnosis (What is your child's problem?)				
Onset ☐ Before Birth ☐ Developed Recently ☐ Injury-Date Known Injury date _____ ☐ Injury-Date Unknown ☐ Onset of walking ☐ Since Birth Other				
Chief Complaint (Why do you want to be seen by the Shrine Hospital? What services are you looking for?)				
Referring Physician				
Street Address	City	State	Zip Code	Country
Previous treatments provided				
Treatments and Surgeries				
X-rays available? ☐ Yes ☐ No	Date of Most Recent X-ray	Date Last Seen by Physician		

Insurance/Primary		
Subscriber Name		
Health Plan		
Name	Subscriber Member Number	Patient Member Number
Primary Care Provider		

Supplemental Information

Referral Source (Select One)

☐ Billboard ☐ Bumper Sticker ☐ Family Member/Self ☐ Newspaper ☐ Unknown ☐ Other
☐ Poster/Flyer ☐ Physician ☐ Other Health Care Professional ☐ School Teacher ☐ School ☐ Radio
☐ Shriner ☐ Television ☐ Friend (non-Shriner) ☐ Watts Line ☐ Website

Family Income for last 12 months

☐ $0 - $10,000 ☐ $10,001 - $20,000 ☐ $20,001 - $30,000 ☐ $30,001 - $40,000 ☐ $40,001 - $50,000
☐ Over $50,000 ☐ Not provided

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***Required Information**

Name of Child

FOR HOSPITAL USE ONLY				
Application Status				
COS Recommendation ☐ Accept ☐ Reject ☐ Screen				Date of Recommendation
COS Comments				
BOG Recommendation	☐ Application Expired	☐ Approved	☐ Denied	Date of Recommendation
Primary Shrine Physician			Care Coordinator	
COS Signature				
BOG Signature				
Service Line	☐ Ortho	☐ Burn	☐ SCI	☐ Plastic
Over Age Patient	☐ Yes	☐ No		
Expedite (indicate specific timeframe if applicable)				