

## Referral Form

Referrals accepted by one of the following. Other referral methods may not be reviewed or cause delay.

**Fax: (512) 600-8149 (Attn: CCC Referral) /Call: (512) 628-1833**

**Enrollment to CCC clinic requires that a patient meet specific criteria that referral coordinator considers: (Circle all that apply)**

- Chronic medical conditions expected to be lifelong and may be life limiting (children on MDCP waiver granted auto enrollment; does not include those on waiting list)
- Neurocognitive involvement and function is grossly impaired
- High medical technology (feeding tube, tracheostomy)
- High utilizer of medical intervention for chronic medical conditions (frequent ED, procedures, hospitalization)
- Multiple specialists (at least 3) or medical problems involving multiple body systems (at least 3)
- Diagnosis of Tuberous Sclerosis Complex (TSC) or suspicion of TSC
- Complex congenital cardiac patients at very high risk (e.g. s/p Norwood, BT shunt dependent, heart failure awaiting transplant)
- Profound level of psychosocial stressors that increase medical risk
- Patient must be less than 17 years of age
- Patient resides in the Austin metropolitan area

**Please note that families must utilize CCC as their primary care provider (PCP) in order to be considered.**

### Referral Information

Is referral in-patient?	<b>YES</b> _____ <b>NO</b> _____	If yes, what facility/room?	_____
Medical Records included?	<b>YES</b> _____ <b>NO</b> _____	Referral Source /Phone number:	_____
Child's Name:	_____	Current Primary Care Provider:	_____
DOB (must be <17yrs):	_____	Address (prefer Austin metro area):	_____
Parent Name:	_____		_____
Phone Number:	_____	Preferred Language:	_____
Does the parent/caregiver know about our clinic?	<b>YES</b> _____ <b>NO</b> _____	Parent Email:	_____
Insurance:	_____	Additional info:	_____