# Dell Children's Medical Group 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

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| Is referral in-patient? | **YES** **NO** | If yes, what facility/room? | ______ |
| Medical Records included? | **YES** **NO** | 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? | **YES** **NO** | Parent Email: | ______ |
| Insurance: | ______ | Additional info: | ______ |