Ann & Robert H. Lurie
Children's Hospital of Chicago
Complex Care Program

COMPLEX CARE PROGRAM REFERRAL FORM (facsimile version)

PLEASE RETURN THIS FORM VIA FAX TO: 312-227-9261 (Fax)
For Questions, Please Call (9a-4p, Mon-Fri): (312) 227-2010

Date of Referral: ______/_______/_______

Patient Name: ____DOB: ______/_______/_______

Lurie MR# (if available): _______________________

Primary Diagnoses (please list):

____

____

Clinical Indication/Reason for Referral:

____

____

Referring Provider Name (required): ____

Are you the PCP? YES / NO *(If "NO", please provide the PCP's name and phone number)*
PCP Name: ____PCP Phone: ____________________________

Referring Office Phone (required): ______________________ Referring Office Fax (required): ___________________

Referring Office Address: ____

How can we keep in touch regarding your patient? Please Provide/Indicate Your Preferred Method of Contact:

☐Office Phone (Direct line required) ____________________ ☐Cell phone__________________________________

☐EPIC In-basket ☐Rapid Connect ☐Office Note/Visit Summary ☐Other____________________

☐Email____

Are you enrolled in Rapid Connect? YES / NO
(If "NO", we will reach out to you regarding enrollment if eligible)

Referring Provider Signature (required): ____

Please complete this form in its entirety. Failure to do so may delay review and/or program enrollment process