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