



APPLICATION FOR TREATMENT

To be completed by parent or guardian (please print).

Application Date (Today's date): _____

1. Child's Information (Required)						* required fields
Child's Last Name*		Child's First Name*		Child's Middle Name		Child's Suffix
Child's Date of Birth* (mm/dd/yyyy)	Gender*	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Primary Language	Interpreter Needed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Child's Home Address*			City*		State / Province*	
Zip / Postal Code*	Country		County		Is home address the mailing address?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Child's Permanent Mailing Address (if different than home address)*			City*		State / Province*	
Zip / Postal Code*	Country		Who does child live with?*		<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other, relationship:	
Primary Phone Number*	<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:	Alternate Phone Number 1	<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:	Alternate Phone Number 2	<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:	

2. Medical Information (Required)		* required fields
What is your child's medical problem or diagnosis?* Please feel free to attach any photographs that may better depict your child's condition		
Onset of problem*	<input type="checkbox"/> Before Birth (congenital) <input type="checkbox"/> Since Birth <input type="checkbox"/> Injury, Date: <input type="checkbox"/> Injury, date unknown	<input type="checkbox"/> Onset of wa king <input type="checkbox"/> Developed recently <input type="checkbox"/> Other, describe:
What medical care or services are you looking for from the Shriners Hospitals for Children®?*		
What previous treatments have been provided?* (Treatments and surgeries, dates etc.)		
Are X-Rays Available? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of most recent X-ray	Date last seen by physician? <i>> Please attach any other medical information you have regarding this problem such as a physician referral letter, or past medical records</i>

3. Referring Physician's Information			* required fields
<input type="checkbox"/> No referring physician			
Referring Physician's Last Name*	Referring Physician's First Name*	Referring Physician's Specialty	
Referring Physician's Office Address		City*	State / Province*
Zip / Postal Code	Country	Phone Number with Area Code	

4. Primary Care Physician (PCP) Information			* required fields
<input type="checkbox"/> Same as referring physician <input type="checkbox"/> No PCP			
PCP Physician's Last Name*	PCP Physician's First Name*	PCP Physician's Specialty	
PCP Physician's Office Address		City*	State / Province*
Zip / Postal Code	Country	Phone Number with Area Code	

5. Mother's Information <input type="checkbox"/> Not applicable * required fields			
Mother's Last Name*	Mother's First Name*	Mother's Middle Name	Mother's Maiden Name
Mother's Home Address <input type="checkbox"/> Same as Child's		City*	State / Province*
Zip / Postal Code*	Country	County	Marital Status <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> separated
Primary Phone Number* <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other	Alternate Phone Number 1 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other	Date of Birth* (mm/dd/yyyy)	

6. Father's Information <input type="checkbox"/> Not applicable * required fields			
Father's Last Name*	Father's First Name*	Father's Middle Name	Father's Suffix
Father's Home Address* <input type="checkbox"/> Same as Child's		City*	State / Province*
Zip / Postal Code*	Country	County	Marital Status <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> single <input type="checkbox"/> widowed <input type="checkbox"/> separated
Primary Phone Number* <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:	Alternate Phone Number 1 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:	Date of Birth* (mm/dd/yyyy)	

7. Legal Guardian's Information (if different from parent) <input type="checkbox"/> Not applicable * required fields			
Legal Guardian's Last Name*	Legal Guardian's First Name*	Legal Guardian's Middle Name	Suffix / Maiden Name
Legal Guardian's Home Address* <input type="checkbox"/> Same as child's		City*	State / Province*
Zip / Postal Code*	Country	County	Relationship to Child*
Primary Phone Number* <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:	Alternate Phone Number 1 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:	Date of Birth* (mm/dd/yyyy)	

8. Other Relative with Custody <input type="checkbox"/> Not applicable * required fields			
Other Relative's Last Name*	Other Relative's First Name*	Other Relative's Middle Name	Suffix / Maiden Name
Other Relative's Home Address <input type="checkbox"/> Same as child's		City*	State / Province*
Zip / Postal Code*	Country	County	Relationship to Child
Primary Phone Number* <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:	Alternate Phone Number 1 <input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> pager <input type="checkbox"/> other:	Date of Birth* (mm/dd/yyyy)	

9. Shriner Information			
Temple Name	Sponsoring Shriner Last Name	Sponsoring Shriner First Name	
Sponsoring Shriner Address		City	State / Province
Zip / Postal Code	Country	Child's ambulatory status?	

10. How did you hear about Shriners Hospitals for Children[®]?			
<input type="checkbox"/> Billboard	<input type="checkbox"/> Newspaper	<input type="checkbox"/> School / Teacher	<input type="checkbox"/> Website / Internet
<input type="checkbox"/> Bumper sticker	<input type="checkbox"/> Physician	<input type="checkbox"/> Shriner	<input type="checkbox"/> Unknown
<input type="checkbox"/> Family Member / Self	<input type="checkbox"/> Other healthcare provider	<input type="checkbox"/> Television	<input type="checkbox"/> Other, describe:
<input type="checkbox"/> Friend (non-Shriner)	<input type="checkbox"/> Poster / Flyer	<input type="checkbox"/> Watts line	