ILLINOIS ELKS CHILDREN'S CARE PROGRAM REFERRAL FORM FOR ASSISTANCE

IF YOU KNOW OF A CHILD IN NEED OF OUR ASSISTANCE, PLEASE PROVIDE THE FAMILY WITH THIS PATIENT REFERRAL FORM. HAVE THE COMPLETED APPLICATION AND ANY DOCUMENTATION SUBMITTED TO THE ADDRESS ON PAGE 2 OF THIS FORM.

IF YOU HAVE ANY QUESTIONS, YOU MAY CALL OUR TOLL FREE NUMBER 1– 800-272-0074

The Illinois Elks Children's Care Program is centered in the orthopedic field. We have sponsored free orthopedic clinics and services for physically challenged children for many years. Information about a clinic in your area may be obtained by calling the toll free number.

The Illinois Elks Children's Care Program is designed to help children with physical challenges which limit their participation in life to its fullest. We are dedicated to providing those services which will enable any child to achieve his/her maximum potential, while growing to adulthood as free as possible from physical limitations.

HOW TO REQUEST ASSISTANCE

The patient referral form serves as the primary source of information in requesting assistance and evaluating the request. Please be as complete as possible and be certain all information is included on/with the form. **Completion of this form does not guarantee assistance**. There are specific medical areas, or types of equipment the program is incapable of funding. We reserve the right to seek additional information from the applicant, the child's physician(s), and any other charity or government program involved with the child or from the proposed service/equipment suppliers. We reserve the right to seek additional price quotes from other suppliers of equipment or services

INSTRUCTIONS

1. **Patients Physician** – Full Complete name along with address. We must have this in order to contact doctor when further medical information is needed.

2. **Family information** – including phone numbers.

3. **Combined income** – Since our program is based upon need, we must be able to assess the financial situation. Requests without income information will be returned.

4. **Hospital/Health Insurance** – We require all insurance benefits to be applied first before we provide assistance.

5. **Patient's physical disability and needs** – Childs primary physician must complete "**Physician Use Only**" section providing basic problem and recommendation for treatment. While we want as complete information as possible, we concentrate upon what specifically needs to be done to help the child. We do not issue blanket approvals for unlimited treatment. We are best suited to handle a specific request for a piece of equipment (i.e. shoes, wheelchair), service (physical therapy), or a defined program of treatment (exercises). Whenever possible, cost estimates, names and address of providers, and specific models or types of equipment should be included. Submit all support information with application. Failure to provide specifics of requested assistance will only delay the processing time.

ILLINOIS ELKS
CHILDREN'S CARE CORPORATION
1201 N MAIN - PO BOX 222
CHATHAM, IL 62629-0222
Phone: 1-800-272-0074 or 217-483-3020
Web Address: illinoiselksccc.org
Email: helpkids@elkscare.org

NEW ____ **RETURN ____**

PATIENT REFERRAL FORM

DATE _____

OFFICE USE ONLY
***SPONSORING LODGE*_____**

PATIENT'S NAME_____
(Last) (First)

PATIENT'S PHYSICIAN_____ **ADDRESS** _____

ADDRESS _____ **CITY**_____**ZIP CODE** _____

CITY_____**ZIP CODE** _____ **DATE OF BIRTH** _____ **AGE**_____ **SEX**_____

TO BE COMPLETED BY PARENTS OR GUARDIAN

MARITAL STATUS: S = Single M = Married D = Divorced

FATHER_____AGE_____ OCCUPATION_____PHONE_____
[S] [M] [D]

MOTHER_____AGE_____ OCCUPATION_____ PHONE_____
[S] [M] [D]

GUARDIAN _____ PHONE_____

PARENTS MONTHLY INCOME_____ RECEIVING PUBLIC AID_____

PRIVATE / GROUP INSURANCE: YES_____ NO_____ STATE MEDICAL CARD: YES_____ NO_____ KIDCARE: YES_____ NO_____

OTHER CHILDREN & AGES _____

TYPE OF BIRTH (Cesarean/Normal) _____ (Length of Labor) _____

WHY IS THIS CHILD HERE TODAY OR_____

WHAT TYPE OF ASSISTANCE IS NEEDED

IS THIS CHILD UNDER THE CARE OF ANY STATE AGENCY OR OTHER CHARITY? _____

NAME OF CHARITY OR STATE AGENCY _____

SIGNATURE _____ RELATIONSHIP TO PATIENT_____

TO BE COMPLETED BY PHYSICIAN

PHYSICAL EXAMINATION / DIAGNOSIS_____

_____

_____

_____

RECOMMENDATION_____

_____

_____

_____

SIGNATURE OF PHYSICIAN_____ DATE_____