Complex Care Service
300 Longwood Avenue, BCH 3077, Boston, MA 02115
Phone 617-355-6162 | Fax 617-730-0621 | bostonchildrens.org

COMPLEX CARE SERVICE Triage Form

Patient Demographics: **Date:**___________________________

Name:____ **Date of Birth**____________________

Gender: Male / Female / Transgender **Interpreter** (Yes / No) ______________ **Language** ____________________

Address:____

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Phone:____ **Boston Children's ID #**__________

Contact Person:_________________________ **Phone** ______________ **Relationship to Patient** __________

Name of Person Filling out this form / Relationship to Patient:___________________________________

Primary Insurance:_____________________________________ **Member I.D** ____________________

Referred by (Name/Institution/Dept)__________________________ **Phone** ______________________

Primary Care Physician:________________________________ **Phone** ______________________

Currently Inpatient: Yes ☐ No☐ Institution: ______________________ **Date of Discharge:** __________

Diagnoses: ____

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Reason for Referral: (*Please check appropriate circles*)

- o Need for assistance with Subspecialty Referrals at Boston Children's Hospital
- o Transferring care to Boston Children's Hospital
- o Establishing Care at Boston Children's Hospital
- o One time Consultation / Second Opinion
- o Help with managing medical complexity
- o Identifying gaps in care

Current Concerns: ____

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Current Specialists outside of Boston Children's Hospital:

Specialty	Reason for Subspecialty Care	Provider's Name/Institution	Office Use Only (*Records Received*)
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	
		Provider: Institution:	

*****Please FAX most recent Discharge & Specialty Notes / Testing Results if patient is followed outside of Boston Children's Hospital.**