Children's Mercy KANSAS CITY

Beacon Program Referral Form

The Beacon Program is a primary care medical home for children with medical complexity. We are not a diagnostic clinic, nor are we aimed at concerns with compliance as a primary reason for referral. We do not co-manage with Special Care Clinic, NEON clinic, or the Home Vent clinic. If a child is being referred that follows in one of those clinics, the PCP needs to coordinate with that clinic prior to the Beacon referral being submitted, to verify a plan for the care of the child.

Patient Name: _____ **DOB:** _____ **MRN:** _____
PCP making referral: _____ **Practice:**_____
Practice email / phone number: _____ **Date of referral:**_____
Parent/Caregiver Name: _____ **Phone Number:** _____

Indicate the Beacon to patient relationship request. Acknowledge the 4 corresponding statements by placing a checkmark in the appropriate boxes.

_ **Beacon to be PCP:**
_ I understand that this child will come to Beacon for all of his/her care once accepted and seen for first visit.
_ This patient resides within 55 miles of Children's Mercy.
_ The family is aware of the referral to the Beacon Program and agreed to the referral
_ Below is a comprehensive and complete history, and no known concerns/problems have been left off.

_ **Community Consult patients:**
_ I understand that I will remain this child's PCP even after establishing with Beacon – including all preventive and well care, orders and prescriptions.
_ I understand that the Beacon team is available to my office staff and me 8am – 4pm M-F, a Beacon provider is available 24/7 and that the families are to call my office first and not reach out to Beacon directly.
_ The family has Kansas Medicaid, lives > 55 miles from Children's Mercy and our office has a contract or is willing to sign a contract with Beacon for these telehealth services.
_ The family is aware of the referral to the Beacon Program and agreed to the referral

Check all that currently apply:

- ☐ Feeding tube / pump
- ☐ Intestinal Ostomy
- ☐ Urinary Ostomy
- ☐ Tracheostomy
- ☐ Ventilator/ CPAP or BiPAP
- ☐ Baclofen Pump
- ☐ VP shunt
- ☐ Vagal Nerve Stimulator
- ☐ Home Oxygen
- ☐ Suction supplies
- ☐ Diapers for child older than 4 yrs
- ☐ Mobility device / wheelchair
- ☐ Home Monitors (apnea or pulse ox)
- ☐ Private Duty Nursing
- ☐ Personal Care Aide
- ☐ In home or out of home therapies
- ☐ Central Line
  - Type of Equipment: _____
- ☐ Other:

Patient problem list:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Any additional information / Primary Reason for referral:

-Sibling Name(s) and DOB

Please complete for the **past 12 months**:

_____Number of sick visits to PCP office

_____Number of ED/Urgent Care visits

_____Number of admissions

Date/s of admission:	Reason and location:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____Number of subspecialists (all)

*Please include all specialists within and outside CM.

*Do not include therapies (physical etc.),Hearing & Speech, Nutrition, Radiology or Lab visits

Name of specialist:	Practice location of Specialist:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Check all that apply:

- ☐ Medicaid ineligible/underinsured
- ☐ Financial/housing/food insecurity
- ☐ Cultural barriers (refugee, recent immigrant, etc)
- ☐ Possible caregiver cognitive impairment
- ☐ Caregiver substance abuse
- ☐ Caregiver mental health concerns
- ☐ Caregiver intimate partner violence
- ☐ Interpreter needed, Language: _____
- ☐ Patient in foster care/child protective system custody
- ☐ Medical Non-compliance or Non-adherence concerns

Please email a completed copy of this form to beaconprogram@cmh.edu of fax to 816-302-9738.

If this referral is URGENT, please contact 816-960-8090 for further assistance.