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:**_____
Date of Referral:_____**Practice Email/Phone #:**_____**Fax#:**_____
Parent/Caregiver Name:_____**Phone #:**_____

Indicate the Beacon to patient relationship request. Acknowledge the 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 during regular business hours, 8am-4pm M-F. There is a Beacon provider on call after hours. Families are to call my office first and not reach out to Beacon directly.
__ The family lives > 55 miles from Children's Mercy and our office has a contract or is willing to sign a contract with Children's Mercy for these telehealth services.
__ The family is aware of and agreed to the Beacon referral for consultative services.

Check all that currently apply:
- ☐ Feeding tube / pump
- ☐ Intestinal ostomy
- ☐ Urinary ostomy
- ☐ Tracheostomy
- ☐ Ventilator
- ☐ CPAP or BiPAP
- ☐ Home oxygen
- ☐ Suction supplies
- ☐ Baclofen pump
- ☐ VP shunt
- ☐ Vagal nerve stimulator
- ☐ Central line: Type of line _____
- ☐ 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
- ☐ Other: _____

Patient problem list:

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

Any additional information / primary reason for referral:

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 (PT/OT), hearing and speech, nutrition, radiology or lab visits

Name of specialist:	Practice location of specialist:

Relevant Social Determinants of Health:

- ☐ Interpreter needed, language: _____
- ☐ Caregiver with special learning/communication needs
- ☐ Culturally sensitive information (refugee, immigrant)
- ☐ Medicaid ineligible/underinsured
- ☐ Financial/housing/food insecurity
- ☐ Caregiver mental health concerns/stressors
- ☐ Involvement with DFS, or Children's Division or Child Protected Services (foster care, welfare concerns)
- ☐ Medical non-adherence concerns

Sibling names(s) and DOB: *Any complex siblings need PCP to complete a separate Beacon referral form

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

If this referral is URGENT, please contact 816-960-8040 for further assistance.