Shriners Hospitals for Children®

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* ☐ Male ☐ Female ☐ Unknown	Primary Language	Interpreter Needed? ☐ No ☐ Yes
Child's Home Address*	City*	State / Province*	
Zip / Postal Code*	Country	County	Is home address the mailing address?* ☐ Yes ☐ No
Child's Permanent Mailing Address (if different than home address)*	City*	State / Province*	
Zip / Postal Code*	Country	Who does child live with?* ☐ Mother ☐ Father ☐ Both ☐ Other, relationship:	
Primary Phone Number* ☐ home ☐ cell ☐ work ☐ no phone ☐ other:	Alternate Phone Number 1 ☐ home ☐ cell ☐ work ☐ pager ☐ other:	Alternate Phone Number2 ☐ home ☐ cell ☐ work ☐ pager ☐ 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* ☐ Before Birth (congenital) ☐ Since Birth ☐ Onset of wa king ☐ Developed recently ☐ Injury, Date: ☐ Injury, date unknown ☐ 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? ☐ No ☐ Yes	Date of most recent X-ray	Date last seen by physician?	➢ *Please attach any other medical information you have regarding this problem such as a physician referral letter, or past medical records*

3. Referring Physician's Information ☐ No referring physician * required fields

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 ☐ Same as referring physician ☐ No PCP * required fields

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	

At least one of sections 5, 6 or 7 must be completed. *Child's Name:* _____

5. Mother's Information ☐ Not applicable * required fields

Mother's Last Name*	Mother's First Name*	Mother's Middle Name	Mother's Maiden Name

Mother's Home Address ☐ Same as Child's	City*	State / Province*

Zip / Postal Code*	Country	County	Marital Status ☐ married ☐ divorced ☐ single ☐ widowed ☐ separated

Primary Phone Number* ☐ home ☐ cell ☐ work ☐ no phone ☐ other	Alternate Phone Number 1 ☐ home ☐ cell ☐ work ☐ pager ☐ other	Date of Birth* (mm/dd/yyyy)

6. Father's Information ☐ Not applicable * required fields

Father's Last Name*	Father's First Name*	Father's Middle Name	Father's Suffix

Father's Home Address* ☐ Same as Child's	City*	State / Province*

Zip / Postal Code*	Country	County	Marital Status ☐ married ☐ divorced ☐ single ☐ widowed ☐ separated

Primary Phone Number* ☐ home ☐ cell ☐ work ☐ no phone ☐ other:	Alternate Phone Number 1 ☐ home ☐ cell ☐ work ☐ pager ☐ other:	Date of Birth* (mm/dd/yyyy)

7. Legal Guardian's Information (if different from parent) ☐ 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* ☐ Same as child's	City*	State / Province*

Zip / Postal Code*	Country	County	Relationship to Child*

Primary Phone Number* ☐ home ☐ cell ☐ work ☐ no phone ☐ other:	Alternate Phone Number 1 ☐ home ☐ cell ☐ work ☐ pager ☐ other:	Date of Birth* (mm/dd/yyyy)

8. Other Relative with Custody ☐ 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 ☐ Same as child's	City*	State / Province*

Zip / Postal Code*	Country	County	Relationship to Child

Primary Phone Number* ☐ home ☐ cell ☐ work ☐ no phone ☐ other:	Alternate Phone Number 1 ☐ home ☐ cell ☐ work ☐ pager ☐ 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[E]?

☐ Billboard	☐ Newspaper	☐ School / Teacher	☐ Website / Internet
☐ Bumper sticker	☐ Physician	☐ Shriner	☐ Unknown
☐ Family Member / Self	☐ Other healthcare provider	☐ Television	☐ Other, describe:
☐ Friend (non-Shriner)	☐ Poster / Flyer	☐ Watts line	