SHRINERS HOSPITALS FOR CHILDREN APPLICATION INSTRUCTIONS

1. Complete pages 1 and 2 of the application. Do not complete the “Sponsoring Shriner” section, the sections marked “For Hospital Use Only,” or the “Chief of Staff” or “Board of Governors” sections.
2. Send the completed application to the nearest Shriners Hospital (listed below).
3. The parents or guardian will be notified if the child is accepted for treatment at Shriners Hospitals.
3. If you have any questions, call toll-free 1-800-237-5055 (in the United States) or 1-800-361-7256 (in Canada).

ORTHOPAEDIC CARE

*** Chicago**
2211 N. Oak Park Ave.
Chicago, IL 60707
773-622-5400

Erie
1645 W. 8th St.
Erie, PA 16505
814-875-8700

Greenville
950 West Faris Road
Greenville, SC 29605-4277
864-271-3444

Honolulu
1310 Punahou St.
Honolulu, HI 96826-1099
808-941-4466

Houston
6977 Main
Houston, TX 77030-3701
713-797-1616

Lexington
1900 Richmond Rd.
Lexington, KY 40502
606-266-2101

Los Angeles
3160 Geneva St.
Los Angeles, CA 90020
213-388-3151

Mexico City
Suchil No. 152, Col. El Rosario Delg.
Coyoacan, 04380 Mexico, D.F.,
Mexico
011-525-618-1120

Minneapolis
2025 E. River Parkway
Minneapolis, MN 55414
612-596-6100

Montreal
1529 Cedar Ave.
Montreal, Quebec, Canada H3G 1A6
514-842-4464

***Philadelphia**
3551 North Broad Street
Philadelphia, PA 19140
215-430-4000

Portland
3101 S.W. Sam Jackson Park Road
Portland, OR 97201-5090
503-241-5090

Salt Lake City
Fairfax Road at Virginia Street
Salt Lake City, UT 84103
801-536-3500

Shreveport
3100 Samford Ave.
Shreveport, LA 71103
318-222-5704

Spokane
911 W. Fifth Ave.
Spokane, WA 99204-2901
509-455-7844

Springfield
516 Carew St.
Springfield, MA 01104
413-787-2000

St. Louis
2001 S. Lindbergh Blvd.
St. Louis, MO 63131-3597
314-432-3600

Tampa
12502 North Pine Dr.
Tampa, FL 33612-9499
813-972-2250

BURN CARE

Boston
51 Blossom St.
Boston, MA 02114
617-722-3000

Cincinnati
3229 Burnet Ave.
Cincinnati, OH 45229-3095
513-872-6000

Galveston
815 Market St.
Galveston, TX 77550-2725
409-770-6600

ORTHOPAEDIC AND BURN CARE

***Sacramento**
2425 Stockton Blvd.
Sacramento, CA 95817
916-453-2000

**** Includes Spinal Cord Injury Rehabilitation Center***

APPLICATION FORM
SHRINERS HOSPITALS FOR CHILDREN

To be completed by parent or guardian

Name of Child: _____
(Last) (First) (Middle)

Permanent
Home Address: _____
(Street) (City/Town) (County)

_____
(State/Province) (Zip Code) (Country)

Mailing Address: _____
(if diffferent) (Street) (City/Town) (County)

Home #: _____ Alternate # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Date of Birth: _____/____/ ____ Sex: M F Child's Social Security No.: _____-_____-_____

Who does child live with primarily? (Circle One) 1. Both Parents 2. Mother 3. Father 4. Other (Name) _____

Name of Mother: _____
(Last) (First) (Middle) (Maiden)

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Father: _____
(Last) (First) (Middle)

Address: _____
(If Different From Mother) (Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

Marital Status: (Circle One) Single Married Separated Divorced Widowed

Name of Legal Guardian: _____
(If Different From Above) (Last) (First) (Middle)

Relationship to child: _____

Address: _____
(Street) (City/Town) (County) (State/Province) (Zip)

Home #: _____ Work # _____
(Area Code) (Phone Number) (Area Code) (Phone Number)

(continued on reverse)

To be completed by Sponsoring Shriner

SPONSORING SHRINER INFORMATION

Sponsoring Shriner's Temple: _____

Shriner's Name: _____

Shriner's Address: _____ Daytime Phone: _____
(Street (City/Town) (State/Province) (Zip) (Area Code) (Number)

_____ _____
Sponsoring Shriner's Signature Date

FOR HOSPITAL USE ONLY:

Return To: _____ Hospital
Address: _____
_____
_____

Date Received: _____
Application Number: _____
Date of Screening Visit: _____
Medical Record Number: _____
Name of Person Initiating Form: _____

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Name of Child: _____

MEDICAL INFORMATION

Problem or Diagnosis (if known): _____

_____ Date First Noticed: _____

Chief complaint (symptom) describe: _____

_____

How long has the child had the problem: From birth ❑ Developed recently ❑ Injury ❑ Date: _____

What other symptoms does your child have (describe) _____

_____

Currently Under Care of:	**Physician**	**Hospital**
Name:	_____	_____
Address:	_____	_____
	_____	_____
Phone #:	_____	_____

Treatment Provided: _____

Surgery/Dates: _____

Other treatment/Dates: _____

X-rays: Yes ❑ No ❑ Date of most recent X-ray _____ (should bring to first visit)

When was child last seen by doctor: _____

Has child been treated at another Shriners Hospital Yes ❑ No ❑ Date of treatment _____

Location/City: _____

FINANCIAL INFORMATION

Total combined family income for last 12 months

❑ $1–$10,000 ❑ $10,000–$20,000 ❑ $20,000–$30,000
❑ $30,000–40,000 ❑ $40,000–$50,000 ❑ over $50,000

INSURANCE INFORMATION

Type Private ❑ HMO ❑ Medicaid ❑ Medicare ❑ State Agency ❑ Other ❑ None ❑

Name of Company or Health Plan: _____

ID Number: _____

Name of HMO Physician: _____

(If this application is approved, further insurance information may be requested by the Hospital in order to assist with services not performed at Shriners Hospitals.)

Name of Person Completing Form: _____ **Relationship** _____ **Date** _____

FOR HOSPITAL USE ONLY:

CHIEF OF STAFF RECOMMENDATIONS

Accept ❑ Reject ❑ Screen ❑

Reason for Rejection: _____

_____ _____
Signature — Chief of Staff Date

ACTION BOARD OF GOVERNORS

Approved ❑ **Denied** ❑

Reason for Denial: Medical ❑ Financial ❑ Non-Compliance Foreign Patient Policy ❑
Overage ❑ Other ❑ _____

_____ _____
Signature Date

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