Daystar Kids Pediatric Respite Center Referral
FAX to (585) 383-0033 or call (585) 385-6287
Visit **daystarkids.org** for more information

DAYSTAR KIDS

Child's Name:_____ (M or F) DOB: ___/___/___ If Newborn: GA: _____

Medicaid:_____ CIN #_____
(required)

Parent/Guardian Name:_____

Address:_____

Phone: _____ (Cell) _____ Email: _____

Child has been evaluated for Early Intervention Services YES NO

Eligibility Information

Diagnoses	ICD9 Code	Diagnosis	ICD9 Code

Please check which of the following criteria are met by the child's current medical condition:

	Requires medical device(s) to maintain health status
	Requires continuous skilled assessment and monitoring of child's medical conditions
	Medical conditions require clinical nursing services and daily nursing supports (medication or oxygen administration, respiratory therapy, cardiac monitoring, seizure management, dressing changes, ostomy care, etc.)
	Special developmental needs requiring intensive therapeutic interventions and/or special education support

Please provide relevant medical history justifying medical eligibility:

_____

_____

_____

_____

_____

_____

Immediate Needs:_____

_____

NOTE: PHI Consent Form must accompany this referral form in order to expedite eligibility decisions. Additional information may be required. Placement is based on eligibility and available openings.

Referring Provider Name:_____

Relationship to patient:_____Agency/Affiliation_____

Email: _____Phone: _____

Referring Provider Signature **(REQUIRED)**: _____Date:_____

Date Received: _____ Reviewed by: _____