



PEDIATRIC DAY HEALTH CENTER

# PATIENT REFERRAL FORM

Please complete this form and submit along with THE MOST RECENT HISTORY AND PHYSICAL via fax at 832.240.3387 or via secure email to [info@joycarekids.com](mailto:info@joycarekids.com)

## CLIENT INFORMATION

Child's Full Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: Male Female  
 Patient Address: \_\_\_\_\_  
 City / State / Zip: \_\_\_\_\_  
 Insurance / ID#: \_\_\_\_\_  
 Diagnosis(es): \_\_\_\_\_  
 ICD Code(s): \_\_\_\_\_  
 Date of Last Visit: \_\_\_\_\_

## PARENT INFORMATION:

Parent / Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Best Contact: Home Cell Email

## PROVIDER INFORMATION:

Physician Name: \_\_\_\_\_  
 Physician NPI #: \_\_\_\_\_ Physician TPI #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 City / State / Zip: \_\_\_\_\_

Admission to Joycare **REQUIRES** a referral for skilled nursing care. If appropriate, confirm by checking the box below:

Skilled Nursing (Required for PPECC)

The patient is **ALSO** being referred to be evaluated in the following areas (Check all that apply):

- Physical Therapy       Speech Therapy       Other, Please Specify Below  
 Occupational Therapy      **If other:** \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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*Prescribed Pediatric Extended Care Centers (PPECC) allow minors from 6 weeks to 20 years of age with medically complex conditions to receive daily medical care in a non-residential setting. When prescribed by a physician, minors can attend a PPECC to receive medical services such as nursing, speech therapy, physical therapy, occupational therapy and developmental services appropriate for their medical condition and developmental status. The minor MUST be stable for out patient medical services and require ongoing nursing care and other basic needs. Please feel free to contact us at 713-929-CARE (2273) for any questions.*