



Patient Application

Pediatric Specialty Care

Orthopaedics
Burns
Spinal Cord Injury
Cleft Lip and Palate



Shriners Hospitals
for Children®

About Shriners Hospitals for Children®

Shriners Hospitals for Children® is a health care system of 22 hospitals dedicated to improving the lives of children by providing pediatric specialty care, innovative research and outstanding teaching programs.

Pediatric Specialty Care

Nineteen Shriners Hospitals for Children® provide care for congenital and acquired orthopaedic conditions, which are conditions involving bones, joints and/or muscles; four hospitals provide acute and rehabilitative care for burn injuries, three hospitals provide rehabilitative care for children with spinal cord injuries, and treatment for cleft lip

and palate is currently offered at eight hospitals. Some Shriners Hospitals for Children® offer care for more than one care specialty. Please check the chart below for the care specialties provided at each location.

Eligibility

Children up to age 18 are eligible for care at Shriners Hospitals for Children® if, in the opinion of our physicians, there is a reasonable possibility they can benefit from the specialized services available. Acceptance is based solely on a child's medical needs. A family's income or insurance status are not criteria for a child's acceptance as a patient.

Application Instructions

Please read the attached application carefully, fill it out completely and send it to the attention of the Applications Coordinator at the nearest Shriners Hospital specializing in the type of treatment you seek for your child. Providing incomplete information may delay the approval process. In addition to the application form, please send any medical history, photographs of your child or other medical information that may help us understand your child's situation and needs. Please also be sure to provide complete, accurate contact information, and keep the hospital updated if that information changes.

If your child is accepted for care, you will be contacted to set up an initial appointment. Please note that it is necessary for a parent or guardian to accompany the child to that appointment. Also, please be aware that, upon acceptance, additional information (such as immunization records, proof of custody, insurance cards, etc.) may be required.

Thank you for your interest in choosing Shriners Hospitals for Children® as a care provider for your child.

For more information about Shriners Hospitals for Children® please visit: www.shrinershospitals.org

or call
(800) 237-5055 in the U.S.
(800) 361-7256 in Canada

Locations and Specialties

Boston

51 Blossom St.
Boston, MA 02114
(617) 722-3000
• Burns
• Cleft Lip and Palate

Chicago

2211 North
Oak Park Ave.
Chicago, IL 60707
(773) 622-5400
• Orthopaedics
• Spinal Cord Injury
• Cleft Lip and Palate

Cincinnati

3229 Burnet Ave.
Cincinnati, OH 45229
(800) 875-8580
• Burns
• Cleft Lip and Palate

Erie

1645 West 8th St.
Erie, PA 16505
(814) 875-8700
• Orthopaedics

Galveston

815 Market St.
Galveston, TX 77550
(888) 215-3109
• Burns

Greenville

950 West Faris Rd.
Greenville, SC 29605
(864) 271-3444
• Orthopaedics

Honolulu

1310 Punahou St.
Honolulu, HI 96826
(808) 941-4466
• Orthopaedics

Houston

6977 Main St.
Houston, TX 77030
(713) 797-1616
• Orthopaedics
• Cleft Lip and Palate

Lexington

1900 Richmond Rd.
Lexington, KY 40502
(859) 266-2101
• Orthopaedics

Los Angeles

3160 Geneva St.
Los Angeles, CA 90020
(213) 388-3151
• Orthopaedics
• Cleft Lip and Palate

Mexico City

Av. del Imán No. 257
Col. Pedregal
de Santa Ursula
Deleg. Coyoacán
Mexico, D.F., 04600
011-52-555-424-7850
• Orthopaedics

Montreal

1529 Cedar Ave.
Montreal, Quebec,
Canada, H3G 1A6
(514) 842-4464
• Orthopaedics

Northern California

2425 Stockton Blvd.
Sacramento,
CA 95817
(916) 453-2000
• Orthopaedics
• Burns
• Spinal Cord Injury
• Cleft Lip and Palate

Philadelphia

3551 North Broad St.
Philadelphia, PA 19140
(215) 430-4000
• Orthopaedics
• Spinal Cord Injury

Portland

3101 S.W.
Sam Jackson Park Rd.
Portland, OR 97239
(503) 241-5090
• Orthopaedics
• Cleft Lip and Palate

Salt Lake City

Fairfax Road at
Virginia St.
Salt Lake City,
UT 84103
(801) 536-3500
• Orthopaedics

Shreveport

3100 Samford Ave.
Shreveport, LA 71103
(318) 222-5704
• Orthopaedics

Spokane

911 West 5th Ave.
Spokane, WA 99204
(509) 455-7844
• Orthopaedics

Springfield

516 Carew St.
Springfield, MA 01104
(413) 787-2000
• Orthopaedics
• Cleft Lip and Palate

St. Louis

2001 South
Lindbergh Blvd.
St. Louis, MO 63131
(314) 432-3600
• Orthopaedics

Tampa

12502 USF Pine Dr.
Tampa, FL 33612
(813) 972-2250
• Orthopaedics

Twin Cities

2025 East River Pkwy.
Minneapolis,
MN 55414
(612) 596-6100
• Orthopaedics



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 Date of Birth* (mm/dd/yyyy)		Gender	Primary Language	Interpreter Needed? <input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		
Child's Home Address*			City*	State / Province*
Zip / Postal Code*	Country	County	Is home address the mailing address? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Child's Permanent Mailing Address (if different than home address)*			City*	State / Province*
Zip / Postal Code*	Country	Who does child live with?* <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> Other, relationship:		
Primary Phone Number*		Alternate Phone Number 1		Alternate Phone Number 2
<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:		<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> other:		<input type="checkbox"/> home <input type="checkbox"/> cell <input type="checkbox"/> work <input type="checkbox"/> no phone <input type="checkbox"/> 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 you child's condition				
Onset of problem* <input type="checkbox"/> Before Birth (congenital) <input type="checkbox"/> Since Birth <input type="checkbox"/> Onset of walking <input type="checkbox"/> Developed recently <input type="checkbox"/> Injury, Date: <input type="checkbox"/> Injury, date unknown <input type="checkbox"/> Other, describe:				
What medical care or services are you looking for from Shriners Hospitals for Children®?*				
What previous treatments have been provided?* (Treatments and surgeries, dates, etc.)				
Are X-Rays Available? <input type="checkbox"/> No <input type="checkbox"/> 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				* required fields
<input type="checkbox"/> No referring physician				
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				* required fields
<input type="checkbox"/> No referring physician <input type="checkbox"/> No PCP				
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				<input type="checkbox"/> Not applicable		* required fields	
Mother's Last Name*		Mother's First Name*		Mother's Middle Name		Mother's Maiden Name	
Mother's Home Address <input type="checkbox"/> Same as Child's			City*		State / Province*		
Zip / Postal Code	Country		County		Marital Status	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number		<input type="checkbox"/> home <input type="checkbox"/> cell	<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:	Alternate Phone Number 1		<input type="checkbox"/> home <input type="checkbox"/> cell
						<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:
							Date of Birth* (mm/dd/yyyy)

6. Father's Information				<input type="checkbox"/> Not applicable		* required fields	
Father's Last Name*		Father's First Name*		Father's Middle Name		Father's Suffix	
Father's Home Address <input type="checkbox"/> Same as Child's			City*		State / Province*		
Zip / Postal Code	Country		County		Marital Status	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number		<input type="checkbox"/> home <input type="checkbox"/> cell	<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:	Alternate Phone Number 1		<input type="checkbox"/> home <input type="checkbox"/> cell
						<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:
							Date of Birth* (mm/dd/yyyy)

7. Legal Guardian's Information				<input type="checkbox"/> 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* <input type="checkbox"/> Same as Child's			City*		State / Province*		
Zip / Postal Code	Country		County		Marital Status	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number		<input type="checkbox"/> home <input type="checkbox"/> cell	<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:	Alternate Phone Number 1		<input type="checkbox"/> home <input type="checkbox"/> cell
						<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:
							Date of Birth* (mm/dd/yyyy)

8. Other Relative with Custody				<input type="checkbox"/> 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* <input type="checkbox"/> Same as Child's			City*		State / Province*		
Zip / Postal Code	Country		County		Marital Status	<input type="checkbox"/> married	<input type="checkbox"/> divorced
					<input type="checkbox"/> single	<input type="checkbox"/> widowed	<input type="checkbox"/> separated
Primary Phone Number		<input type="checkbox"/> home <input type="checkbox"/> cell	<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> other:	Alternate Phone Number 1		<input type="checkbox"/> home <input type="checkbox"/> cell
						<input type="checkbox"/> work <input type="checkbox"/> no phone	<input type="checkbox"/> 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?			
<input type="checkbox"/> Billboard	<input type="checkbox"/> Newspaper	<input type="checkbox"/> School Teacher	<input type="checkbox"/> Website / Internet
<input type="checkbox"/> Bumper sticker	<input type="checkbox"/> Physician	<input type="checkbox"/> Shriner	<input type="checkbox"/> Unknown
<input type="checkbox"/> Family Member / Self	<input type="checkbox"/> Other healthcare provider	<input type="checkbox"/> Television	<input type="checkbox"/> Other, describe
<input type="checkbox"/> Friend (non-Shriner)	<input type="checkbox"/> Poster / Flyer	<input type="checkbox"/> WATS line	