VERMONT
DEPARTMENT OF HEALTH
Agency of Human Services

Pediatric High-Tech Nursing Program
REFERRAL FORM

Directions: A Medical Provider (MD) must complete this **ENTIRE** form and fax to 802-863-6344. *You are encouraged to attach additional information. You may be contacted if more information is needed.* **Questions?** Call CSHN at (800) 660-4427

PROGRAM ELIGIBILITY CRITERIA – The child must meet all of the below:

☐Have Vermont Medicaid,
☐Be a Vermont resident residing in-state,
☐Be less than 21 years old,
☐Require more individual and continuous skilled nursing care than can be provided in a skilled nurse visit, and
☐Require care outside the scope of services provided by a Home Health Aid/PCA.

CHILD'S INFORMATION

Full Name				Parent/Guardian Name(s)	
Primary Diagnosis				ICD-10 Code	Date of Diagnosis
Sex ☐ M ☐ F	Age	Date of Birth	Medicaid ID No.	Interpreter Needed? ☐Yes ☐No Language:	
Home Address					
City		State **VT**	Zip	Phone	
Mailing Address, if different					

REFERRING PROVIDER INFORMATION

Full Name	Medicaid Provider#	Practice Care Coordinator Name
Practice Name & Address		

City	State	Zip	Phone

LEVEL OF CARE – The following information does not guarantee services.

Which of the following characterizes this child's risk for hospitalization:
- ☐Currently hospitalized
- ☐Little or no risk of hospitalization
- ☐Multiple hospitalizations in the past 12 months (2 or more inpatient admissions)
- ☐Increased risk due to chronic fragile state

Which description best fits this child's overall status? This child is…
- ☐Stable with no heightened risk(s) for serious complication and death
- ☐Temporarily facing high health risks but is likely to return to being stable without heightened risk(s) for serious complications and death
- ☐Likely to remain in fragile health and have ongoing high risk(s) of serious complications and death

Needs: ☐mechanical ventilation ☐airway clearance ☐IV administration ☐observation and intervention
Anticipated Duration: ☐<3 months ☐3-6 months ☐6-12 months ☐>12 months
Equipment: ☐mechanical ventilator ☐PICC/central line ☐peripheral line ☐enteral tube ☐suction

MD Signature	Date	FOR VDH USE ONLY Date Received Initials