Gift of Life International, Inc.

NEW PATIENT APPLICATION FORM DISTRICT 7020

DATE: _____

Referred by Rotary Club of: _____

Contact info (name, phone, email, fax) _____

_____

PATIENT INFORMATION: **Date of Birth:** _____ **Age:** _____ **Sex: M** _____ **F** _____

Cardiac Defect Diagnosis: _____

Home Address _____

Phone Number _____

Mothers full name _____

Fathers full name _____

Siblings _____

Does Guardian / Child understand English? _____

Dietary Restriction? _____

Financial Information:

Family Employment information: _____

Employer Address and Phone: _____

Approximate Household Income: _____

Resources to travel to Kingston JA? _____

Immigrations Issues: **Indicate if the patient or guardian require the following documents.**

Passport Y___N____ **VISA Y_____N_____** **PERMIT Y___N_____**

MEDICAL INFORMATION: **Provide Dr. Charmain Scott with the following:**

- **Initial Diagnostic Evaluation**
- **Progress notes if any**
- **Height and Weight**
- **Allergies to any Medications**
- **EKG**
- **Echo report with tape or CD**
- **Chest X-Ray if done**
- **Does the child have any other medical issues?**

Review Outcome:

This child has been accepted to the Gift of Life Program Y_____N_____

Reason if not accepted_____

Date of Planned Surgery:_____

Date of First appointment with Dr. Charmain Scott at BHC:_____

Host Rotary Club:_____

Main contact:_____

Phone:_____

Where will the patient and guardian stay in Kingston?_____

_____

Notes:_____

_____

_____