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	Fax

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
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