



Referral Form

Child name: _____

Parent / Guardian name: _____

Parent / Guardian email : _____

Parent / Guardian telephone: _____

Diagnosis & pertinent info: _____

Current Hospital: _____ Date admission: _____

Hospital Transferred To or From: if applicable: _____

Eligibility Criteria

- Newborn up to 18 years of age **AND**
- Medically complex diagnosis, congenital or acquired, requiring current acute treatment **AND**
- Resides in northern or central Nevada or surrounding northeastern rural California **AND**
- Inpatient care thirty (30) days or greater within ninety (90) miles of home **OR**
- Inpatient or outpatient care fourteen (14) days or greater (*real or anticipated*), ninety (90) miles or greater from home
- **Exceptions on a case-by-case basis, please check with Tiny Toes first:**
 - Intensive outpatient treatment such as infusion services

Exclusion criteria:

- Premature infants without a medically complex condition
- Children with chronic medical complex condition(s) **not** undergoing current acute treatment
- Children with a critical illness, full recovery anticipated

HCP / Title submitting referral (print): _____

Healthcare Professional (HCP) = MD, Social Worker or RN Case Manager

HCP contact number: _____

HCP signature: _____ **Date:** _____

Signature attests criteria met and permission from parent / guardian to submit this form received.

Parent / Guardian signature: _____

Signature attests permission to release information on this form is granted.

Submit form via email to: admin@tinytoesfoundation.org

775-530-4782

Tiny Toes provides support by assisting with direct pay of bills for living or medical travel expenses.