ChIRP Referral Form *Revised 9/12/19*

Patient's Name: _____ **MRN#:** _____

DOB: _____ **Age:** _____

Date of Referral: _____ **Gestational Age:** _____

PLEASE COMPLETE FORM AND FAX TO: (734) 998-2398

CD or other media may be mailed to: C.S. Mott Children's Hospital, ChIRP, F3970 UH-South, 1500 E. Medical Center Drive, Ann Arbor, MI 48109

BRIEF SURGICAL DIAGNOSIS:
LENGTH OF BOWEL REMAINING:
ICV PRESENT:
BRIEF NUTRITION HISTORY AND CURRENT FEEDS (I.E IS THE PATIENT ON TPN AND TUBE FEEDS?):
BARRIERS TO FEEDING ADVANCEMENT:
IS THE PATIENT CHOLESTATIC?
DOES THE PATIENT HAVE A HISTORY OF LINE INFECTIONS?
LAST BROVIAC AND LENGTH:

LAST G-TUBE - SIZE G-TUBE OR GJ-TUBE
MOST RECENT CONTRAST IMAGING AND RADIOGRAPHIC STUDIES:
OTHER MEDICAL CONSULTS DURING HOSPITALIZATION:
PSYCHOSOCIAL CONERNS/SOCIAL WORK:
ANTICIPATED DISCHARGE DATE:
OTHER:

If the referral is from outside UMHS, please include the following documentation along with this form:

- Reports of operations
- Recent discharge summaries
- Recent clinic notes
- Laboratory flow sheet
- Current medications with dosing
- TPN prescription
- Home care agency
- CD of most recent line placement x-ray and contrast studies

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The CHIRP team will see referred patients as soon as all team members are available. All recommendations will be communicated to the inpatient care team via email contact or phone conversations.