MIAMI CHILDREN'S HOSPITAL
We're here for the children

Date of Admission: ____ / ____/ ___
☐ MD ☐ PCC ☐ OPC ☐ Out of Country
Other: _____

TO: Miami Children's Hospital Admission Office
FAX (305) 663-8466

FROM: Referring Physician _____

Call-back phone number: _____–_____–_____

Contact person for questions: _____

DIRECT ADMISSION RESERVATION

Please follow these seven quick steps and fax immediately to ensure prompt placement of your patient.

1. Patient Name: _____ _____
First name *Last name*

2. Date of Birth: __ __ / __ __ / __ __

3. Diagnosis: _____

4. Planned Procedure: _____

5. PATIENT TYPE: *(This portion is essential to facilitate optimal communication with your patient's insurance payor.)*

☐ Observation – Anticipated needs for medical and nursing care are for less than a day and not more than 2 days.

☐ Inpatient – Needs ongoing medical and nursing care for a day or longer.

6. PATIENT CATEGORY:

☐ Elective – Patient's condition permits time to plan hospital stay

☐ Urgent – Care must begin within the next 48 hours

☐ Emergent – Immediate assessment &/or interventions required

7. Physician: _____, _____
Print first & last name

Signature: _____MD/DO

Miami Children's Hospital Admitting Office Fax Number: (305) 663-8466
Please call Admitting Nurse (305) 662- 8259 to confirm receipt of request.
If it is your preference to use the internet instead of fax,
please go to: www.mch.com or electronically mail: mchreservations@mch.com

For Hospital Personnel

Patient Arrival Time: _____
Admitting MD Notified: _____
Room Assigned: _____
Patient Transported: _____

Insurance Information

Insurance Name: _____

Policy #: _____

Group #: _____
Patients with NHP, CMS, JMS, must obtain authorization prior to arrival.