Children's Healthcare of Atlanta

Admission Request Form

Date Request Submitted:_____ Date of Admission: _____ Date of Procedure_____

Type of Admit:

☐ Elective/Non-emergent

☐ Prior Day admit

☐ Urgent/Same Day admit

Hospital:

☐ Children's at Egleston

☐ Children's at Hughes Spalding

☐ Children's at Scottish Rite

Admit type:

☐ Inpatient

☐ OBS

Request for specific floor: _____

Is patient older than 20 years of age? (If yes, need separate approval by campus medical director)

☐ No ☐ Yes

Patient Information Name:_____ Date of birth: _____

Legal Guardian name:_____ Legal Guardian phone number: _____

Primary diagnosis:_____ Estimated length of stay (ELOS): _____

Physician Information Admitting Physician:_____ Practice: _____

Contact person at practice:_____ Contact phone number: _____

Patient Access Insurance Verification Insurance Company: _____

_____ Precertification phone number:___

_____ Contact person: _____

Authorization/reference number:_____ Approved number of days: ___

Are there any ambulance transport needs during this hospitalization? ☐ Yes ☐ No

Authorization number for transport to Children's: _____
(if transport to be provided by Children's Transport Service)

Comments:

PLEASE RETURN COMPLETED FORM TO THE CHILDREN'S TRANSFER CENTER

FAX: 404-785-7779 or
EMAIL: transfercenter@choa.org

For Internal Use Only
Patient Access: Fax this form to Mary Melvin 404-785-7977
PFS: Copy to Managed Care if no contract with originating hospital

Revised June 2016