



NICU Growth and Developmental Support Program Referral Form

Please fax referral form to NICU GraDS Program Coordinator – Yara Monteiro

<u>Phone:</u> (617) 355-6622 <u>Fax:</u> (617) 730-4681, <u>BCH Pager:</u> (617) 355-7243 ID 6011

<u>Email:</u> <u>NICUGraDS@childrens.harvard.edu</u>

Appointment should be scheduled prior to discharge or transfer. Discharge summary should be faxed when available, but does not need to be faxed at the same time as the referral form.

Infant's name in hospital:	pital: after discharge:		
If multiples, list name of siblings and	d their dispositi	on:	
DOB: GA:_	weeks	days BW:	MRN:
Eligibility Criteria:			
 □ Premature infants born <32 weeks or <1500g birth weight □ Infants born between 32-35 weeks with at least one diagnosis listed below: □ IVH (grade) □ White matter injury (PVL) □ IUGR □ Surgical NEC 			
☐ Surgical PDA ☐ Discha	rged home on	O2 G-tu	-
☐ Infants with a genetic diagnosis identified for follow up with Dr. Monica Wojcik/Genetics/NICU GraDS— contact monica.wojcik@childrens.harvard.edu for questions			
Referring Hospital/Provider:			
Hospital of birth: Tentative discharge /transfer Date: To: \[\subseteq \text{Home } \subseteq \text{Level II:} \]			
Family/Follow-up Information			
Parents' first and last names:			
Best way to contact- Phone:Email : Interpreter needed? ☐ Yes ☐ No; If so, what Language:			
Legal Guardian other than parent			
Best way to contact phone:		Email	
Early Intervention Program			
I, the parent/guardian ofauthorize the release of a copy of my child's discharge summary and other pertinent medical records to Dr. Jane Stewart, Clinical Director, NICU GraDS Program, Boston Children's Hospital, Fegan Building, 10 th Floor, 300 Longwood Avenue, Boston, MA 02115.			
Print Name Sign	1		Date