Thank you for your interest in becoming a patient at Texas Scottish Rite Hospital for Children.

Criteria to Become a Patient

- Luke Waites Center for Dyslexia and Learning Disorders patients must be between the ages of 5 and 14 years.
- The child's condition should offer hope of improvement through the services provided by the hospital.

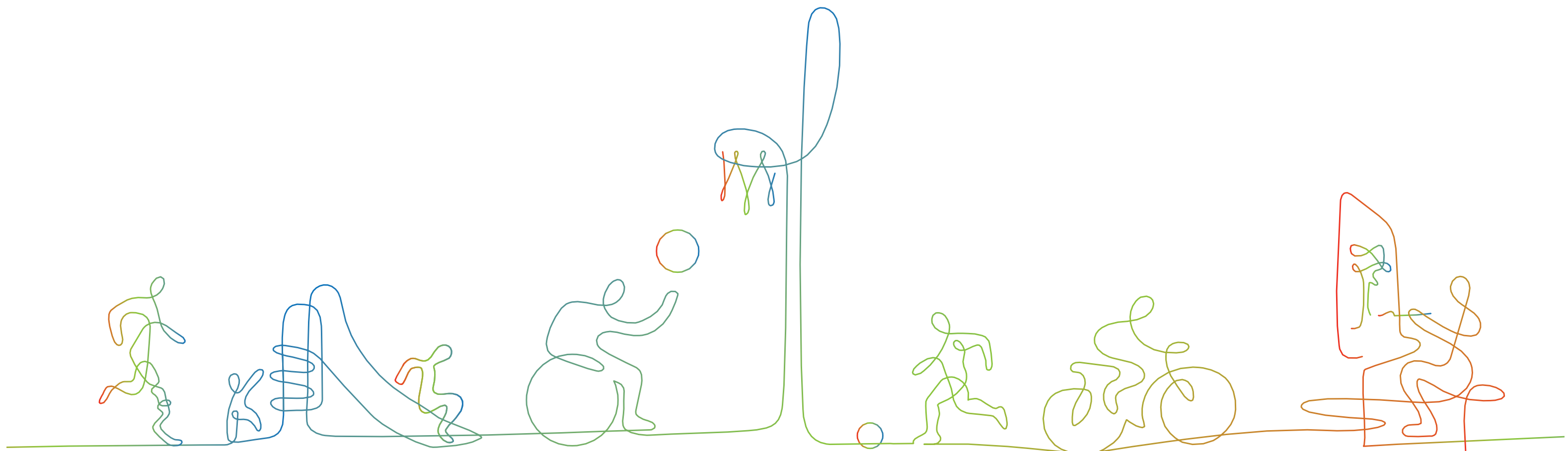
Please mail the completed form/application to the attention of Patient Access at the address listed on the application.

Next Steps

All applications are reviewed by hospital staff on a case-by-case basis when received. If the child meets the criteria listed above, and needs an evaluation for dyslexia, an appointment will be scheduled and a written notice will be sent to the parents/legally responsible persons.

Need Help?

For help with the dyslexia application process, please contact the Luke Waites Center for Dyslexia & Learning Disorders at 214-559-7815.



TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Patient Referral Information

1 Has this child ever been a patient at Texas Scottish Rite Hospital for Children? ☐ No ☐ Yes MR#______________
¿Ha sido este niño alguna vez paciente del Hospital para Niños Texas Scottish Rite?" *No* Sí *# de expediente*

2 Child's name ____
(Nombre del Niño) *Last (Apellido)* *First (Primer Nombre)* *Middle (Segundo Nombre)* *Suffix (Jr. Sr. Etc)*

☐ Male *(Masculino)* ☐ Female *(Femenino)* Age *(Edad)*____ Religious preference ______________
Preferencia religiosa

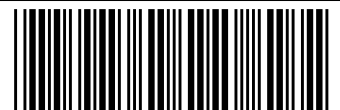
3 Date of child's birth ________/________/____________ Social Security Number ______________
Fecha de nacimiento del niño Mo (Mes) Day (Día) Yr (Año) Número de Seguro Social

4 Does this child speak English? ☐ No ☐ Yes If no, child?s primary language______________
¿Habla este niño inglés? *No* Sí Si no, ¿Cuál es el primer idioma del niño?

5 The child's biological/adoptive parents are: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Los padres biológicos/adoptivos del niño son: *Solteros* *Casados* *Divorciados* *Viudos* *Separados*

6 With whom does the child primarily reside? *(¿Principalmante, con quién vive este niño?)*
☐ Father *Padre* ☐ Mother *Madre* ☐ Managing Conservator #1 *Tutor Legal Asignado por la Corte #1* ☐ Managing Conservator #2 *Tutor Legal Asignado por la Corte #2* ☐ Other *Otro*

Father *(Padre):*	**Mother *(Madre):***
Name (Nombre) *Date of Birth (Fecha de nacimiento)*	*Name (Nombre)* *Date of Birth (Fecha de nacimiento)*
Social Security Number (Número de Seguro Social)	*Social Security Number (Número de Seguro Social)*
Address *(Dirección)*	Address *(Dirección)*
City (Ciudad) *County (Condado)*	*City (Ciudad)* *County (Condado)*
State (Estado) *ZIP (Zona Postal)*	*State (Estado)* *ZIP (Zona Postal)*
(_______) *Primary phone (Teléfono Principal)*	(_______) *Primary phone (Teléfono Principal)*
(_______) *Secondary phone (Teléfono Secundario)*	(_______) *Secondary phone (Teléfono Secundario)*
(*Email (Correo Electrónico)*	*E–mail (Correo Electrónico)*
Primary Language (Primer idioma)	*Primary Language (Primer idioma)*
Employer (Empleador)	*Employer (Empleador)*



TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Patient Referral Information

7 If there has been a court decision creating or affecting the legal custody (managing conservatorship) of the child, please provide a copy of the court order and complete the following: *(Si ha habido alguna decisión de la corte que haya creado o afectado la custodia legal (custodia legal asignada por la corte) del niño, por favor, proporcione una copia de la orden de la corte y complete lo siguiente)*

State and County of Court (Estado y Condado de la Corte) *Date (*Fecha) *Case Number (Número del Caso)*

Managing Conservator #1 (Tutor Legal Asignado por la Corte #1)

☐ Sole *Total Asignada* ☐ Joint *Compartida Asignada* ☐ Possessory *Posesión Total*

Name (Nombre) *Date of Birth (Fecha de nacimiento)*

Relationship to Child (Relación con el niño) *Social* Security # *(Numero de Seguro Social)*

Address *(Dirección)*

City (Ciudad) *County (Condado)*

State (Estado) *ZIP (Zona Postal)*

( )
Primary phone *(Teléfono Principal)*

(________)
Secondary phone *(Teléfono Secundario)*

Email (Correo Electrónico)

Primary Language (Primer idioma)

Employer (Empleador)

Managing Conservator #2 (Tutor Legal Asignado por la Corte #2)

☐ Sole *Total Asignada* ☐ Joint *Compartida Asignada* ☐ Possessory Posesión Total

Name (Nombre) *Date of Birth (Fecha de nacimiento)*

Relationship to Child (Relación con el niño) *Social Security # (Numero de Seguro Social)*

Address *(Dirección)*

City (Ciudad) *County (Condado)*

State (Estado) *ZIP (Zona Postal)*

( )
Primary phone *(Teléfono Principal)*

(________)
Secondary phone *(Teléfono Secundario)*

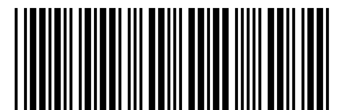
Email (Correo Electrónico)

Primary Language (Primer idioma)

Employer (Empleador)

8 For the purpose of coordinating appointments and records, please list any children in your immediate family who are, or have been, patients of Texas Scottish Rite Hospital for Children. *(Con el propósito de coordinar citas y expedientes, por favor, escriba el nombre de cualquier niño en su familia inmediata, quien sea o haya sido paciente del Hospital para Niños Texas Scottish Rite)*

Name ____________________ Date of birth_____/______/____________ MR #____________________
Nombre *Fecha de nacimiento* *# de expediente*



TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Patient Referral Information

AGREEMENT AND ACKNOWLEDGMENT OF PARENT(S) OR MANAGING CONSERVATOR(S)
ACUERDO Y RECONOCIMIENTO DE PADRE O TUTOR(ES) LEGAL(ES) ASIGNADOS POR LA CORTE

9 Texas Scottish Rite Hospital for Children (TSRHC) does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment or participation in its programs, services and activities, or in employment. For further information about this policy, please contact:

Provider Name: Texas Scottish Rite Hospital for Children (TSRHC)
Contact Person / Section 504 Coordinator: Administrator
Telephone number: (214) 559 –7602, TDD or State Relay number: 1–800–735–2989

El Hospital para Niños "Texas Scottish Rite" (TSRHC, siglas en inglés) no discrimina contra ninguna persona en base de raza, color, origen nacional, incapacidad o por la edad en admisión, tratamiento o participaciónen sus programas, servicios y actividades, o en su empleo. Para información adicional acerca de esta información, por favor, comuníquese con:

Nombre del Proveedor: Hospital para Niños "Texas Scottish Rite" (TSRHC)
Persona de Contacto/Coordinador de la Sección 504: Administrador,
Número de Teléfono: (214) 559–7602, Niños de Aparato de Telecomunicación para personas con Deficiencia de, Audición (TDD, siglas en inglés) o el número para trasmitir del estado: 1–800–735–2989

10 By signing below, I or we, hereby certify that as natural or adoptive parent(s) and/or managing conservator(s), I am/we are legally authorized to consent to medical care of the child herein named. I agree to notify the Hospital in the event that there is a change in the above mentioned relationship.

Firmando a continuación, yo, o nosotros, certificamos que como padre(s) natural(es) o adoptivo(s) y/o tutor(es) legal(es) asignado(s) por la corte, estoy (estamos) legalmente autorizado(s) para dar consentimiento para atención médica para el niño aquí mencionado. Estoy de acuerdo en notificar al Hospital en el evento de que haya un cambio en la relación mencionada anteriormente.

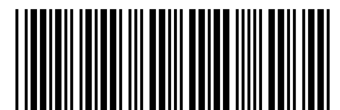
MOTHER'S SIGNATURE *(FIRMA DE LA MADRE)* DATE *(FECHA)*

FATHER'S SIGNATURE *(FIRMA DEL PADRE)* DATE *(FECHA)*

Or Managing Conservator's Signature (if appropriate) DATE *(FECHA)*
O Firma del Tutor Legal Asignado por la Corte (si es apropiado)

11 Recommendation by a Texas Master Mason *(Recomendación de un Venerable Maestro Masón de Texas)*

Signature *(Firma)* Please Print Name *(Nombre en letra de molde)* Lodge Number *(Número de Logia)*



TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Patient Referral Information

Section A –**REQUEST FOR ORTHOPEDIC/MUSCULOSKELETAL EVALUATION** ***(completed by MD)***

Diagnosis________________________________ Date of onset __________

Describe problem or need ________________________________

____

____

Pertinent exam findings and history* ________________________________

____

Developmental status (Cognitive, Motor, Social)** ________________________________

____

* **Please attach related X-rays, medical records or other clinically significant information**

** **Please attach a copy of a developmental screening test, if applicable**

Section B –**REQUEST FOR LEARNING DISORDER EVALUATION** ***(completed by MD)***

NOTE: The enclosed Educational Background Information form **MUST** be completed for application to be processed.

Grade level __________ School name ____________________ School district ______________

Provide established diagnoses? ☐ No ☐ Yes

Purpose of referral________________________________

____

Describe learning problem(s)________________________________

____

Has previous testing been done? ☐ No ☐ Yes (if yes, note date, place of testing and attach records)

____

PHYSICIAN'S SIGNATURE ________________________________ **DATE** __________

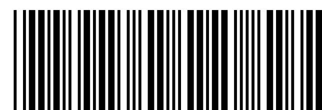
PHYSICIAN'S NAME ______________________ **MEDICAL LICENSE #** ______________
Print or Type

PHYSICIAN'S ADDRESS ________________________________
Street *Suite #*

____
City *State* *County* *ZIP*

PHONE(____)______________________ **FAX** (______)______________________

E-MAIL________________________________



INSTRUCTIONS FOR COMPLETING PAPER PATIENT REFERRAL INFORMATION

1. If your child has ever been seen at Texas Scottish Rite Hospital for Children, please indicate this by checking yes or no. Any other information you can provide us, such as the year seen and Texas Scottish Rite Hospital for Children (TSRHC) medical record patient number (MR#), will also be helpful. (*Si su niño ha sido atendido anteriormente en el Hospital de Niños "Texas Scottish Rite", por favor, indíquelo marcando sí o no. También sería de ayuda cualquier otra información que usted nos pueda proporcionar, tales como, el año que fue visto como paciente en el Hospital para Niños "Texas Scottish Rite" ("TSRHC", siglas en inglés), el número de expediente médico del paciente ("MR#").*

2. Print child's name as it appears on the birth certificate, check the box to indicate gender, fill in the age of the child, and if you have a religious preference, please note here. (*Escriba en letra de molde el nombre del niño según aparece en el certificado de nacimiento, marque la casilla para indicar el género, anote la edad del niño y si usted tiene una preferencia religiosa, por favor, indíquelo aquí.)*

3. Enter child's date of birth and social security number. If no social security number exists, enter "none*". (Anote la fecha de nacimiento del niño y el número de seguro social. Si no tiene número de seguro social, escriba "ninguno".)*

4. Please indicate if child is able to speak English by checking yes or no. If no, indicate what language is spoken. We will strive to provide needed translation services. *Por favor, indique si el niño puede hablar en inglés, marcando "sí o no". (Por favor, indique si el niño puede hablar en inglés, marcando sí o no. Si no, indique el idioma que habla. Haremos todo lo posible por proporcionarle los servicios de traducción necesarios.)*

5. To assist us in identifying the person who may legally sign consents, please check marital status of parents. If child's mother was not married to child's father at the time of birth, check "single." If biological parents are divorced, we will look to the person designated as the managing conservator for consent to evaluate and treat child. (*Para ayudarnos a identificar a la persona quien pudiera legalmente firmar los consentimientos, por favor, marque el estado civil de los padres. Si la madre del niño no estaba casada con el padre del niño al momento del nacimiento, marque "soltera". Si los padres biológicos están divorciados, nosotros buscaremos a la persona designada con la autorización legalmente asignada por la corte para dar el consentimiento de evaluar y tratar al niño.)*

6. Please indicate whom the child lives with most of the time. (Multiple boxes may be checked.) *(Por favor, indique con quién vive el niño la mayor parte del tiempo. (Pudiera marcar varias casillas))*

   For each box that was checked on item #6, please complete the corresponding box below. (*Para cada casilla que marcó en el punto #6, por favor, complete la siguiente casilla correspondiente.*

   Father's Name: biological or adoptive. If adoptive, complete section 7. Foster parents and stepparents are not considered adoptive parents until adoption is final, at which time there will be a new birth certificate issued and/or legal papers signed by a judge. Please print address where biological or adoptive father resides. Please indicate father's/mother's primary language. Please include the information about the father's employer; if not employed, write "none." (*Nombre del Padre: biológico o adoptivo. Si es adoptivo, complete la sección 7. Padres de crianza ("foster parents") y padrastros/madrastras no son considerados padres adoptivos hasta finalizada la adopción, en la cual, en ese momento, se emitirá un nuevo certificado de nacimiento y/o papeles legales firmados por un juez. Por favor, escriba en letra de molde, la dirección donde vive el padre biológico o adoptivo. Por favor, indique el idioma primario del padre/madre. Por favor, incluya la información sobre el empleador del padre; si no está empleado, escriba "ninguno".*

   Mother's Name: (use the same instructions as above). *Nombre de la Madre: (siga las mismas instrucciones arriba indicadas).*

7. Complete this portion if biological parents are divorced, or another person or agency has been named managing conservator(s). List state and county of court, date of the decree and case number. (*Complete esta porción si los padres biológicos están divorciados u otra persona o agencia ha sido designada por la corte con la custodia legal. Incluya el estado y el condado de la corte, la fecha del acta y el número del caso.)*

   In the "Managing Conservator" information, please indicate whether this person is a "sole" conservator, "joint" conservator, or "possessory" conservator. All information needs to be completed for each conservator of the child. (*En la información del Tutor Legal Asignado por la Corte, por favor, indique si esta persona tiene la Custodia Asignada "Total," "Compartida," o de "Posesión". Se necesita completar toda la información por cada Tutor Legal Asignado del niño.)*

8. To help in the coordination of appointments and treatment plans, please print the full name and date of birth of any other children in your family who are now or have ever been patients at Texas Scottish Rite Hospital for Children. If you know their TSRHC medical record patient numbers (MR#), this information will also be helpful. (*Para ayudarnos con la coordinación de las citas médicas y la planificación de tratamiento, por favor, escriba en letra de molde el nombre completo y la fecha de nacimiento de cualquier otro niño en su familia que es o ha sido paciente del Hospital para Niños "Texas Scottish Rite". Si usted sabe su número de identificación ("MR#") como paciente del Hospital, esta información también será de mucha ayuda.*

9. This agreement and acknowledgment gives the hospital staff permission to evaluate your child and explains certain provisions of state law. (*Este reconocimiento y acuerdo le otorga permiso al personal del hospital para evaluar a su niño y explicar ciertas leyes establecidas por el estado.)*

   Biological or adoptive parent(s) should sign the application. If a managing conservator has been appointed, that individual should complete section 7 and then sign the application. Other relatives, such as stepparents, grandparents, and foster parents may not sign in this space. (*Los padres biológicos o adoptivos deberán firmar la solicitud. Si la corte ha asignado n Tutor Legal, esa persona deberá completar la sección 7 y luego firmar la solicitud. Otros parientes, tales como, padrastro/madrastra, abuelos y padres de crianza no pueden firmar en este espacio.*

   If an individual other than a parent has been appointed as the child's managing conservator, that individual should sign here and assure that Section 7, specifying the court ruling, is completed. *Si una persona que no sea el padre/madre ha sido asignada para ser el Tutor Legal Asignado por la corte del niño, esa persona deberá de firmar aquí y asegurarse de que la sección 7, especificando la decisión de la corte, haya sido completada.*

10. Because the Hospital was founded by Texas Scottish Rite Masons, many Masons actively support the Hospital's purpose by recommending children for treatment here. This space was provided for the signature of a Mason who recommended the child for treatment, if there was one involved. If there was no Mason involved in your referral, Hospital staff will complete this section as necessary. *(Debido a que el Hospital fue fundado por los Masones "Scottish Rite" de Texas, muchos Masones apoyan activamente el objetivo del Hospital recomendando niños para su tratamiento. Este espacio fue provisto para la firma del Masón que recomendó al niño para tratamiento, si hubo uno involucrado. Si el referido no fue hecho por un Masón, el personal del Hospital completará esta sección como sea necesario.)*

INSTRUCTIONS FOR THE REFERRING PHYSICIAN:
(INSTRUCCIONES PARA EL MÉDICO QUE ESTÁ HACIENDO EL REFERIDO)

For Orthopedic/Musculoskeletal Evaluation: If a definitive or provisional diagnosis has been made, please fill in this information. If condition is the result of illness or injury, please include date of onset. A pertinent summary of the child's problems and your reason for referring the patient to us is essential. Any information you can provide on the patient will assist in our evaluation and treatment. (*Para una Evaluación Ortopédica/Músculo-Esquelética: Si se ha hecho un diagnóstico definido o provisional, por favor, complete esta información. Si la condición es el resultado de una enfermedad o de una lesión, por favor, incluya la fecha en que ocurrió. Es esencial que se haga un resumen apropiado sobre los problemas del niño y su razón para referirnos al paciente. Cualquier información que nos pueda proporcionar acerca del paciente nos ayudará en nuestra evaluación y tratamiento.)*

For Learning Disorder Evaluation: It is essential that you include a pertinent summary of the child's problems and the reason for referring the patient to us. All the information provided on the patient will assist in our evaluation and treatment. Use the Required School Related Background Information form to help gather needed documentation. If previous educational, behavioral, or psychological testing has been done, please send copies of all results with the application. (*Para Evaluación de Trastorno del Aprendizaje: Es esencial que usted nos incluya un resumen pertinente de los problemas del niño y la razón por la cual nos está refiriendo este paciente. Toda información proporcionada relacionada al paciente nos ayudará en nuestra evaluación y tratamiento. Utilice el formulario Antecedentes Requeridos Relacionados a la Escuela para recopilar la documentación necesaria. Si se han efectuado previamente evaluaciones educativas, de comportamiento o psicológicas, por favor, envíe las copias de todos los resultados con la solicitud.)*

NOTICE CONCERNING COMPLAINTS:
(NOTIFICACIÓN RELACIONADAS A QUEJAS)

(Texas State Law requires us to include the following statement in its entirety)
(La ley del estado de Texas requiere que incluyamos la siguiente declaración completa)

Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:. (*Quejas acerca de los médicos, así como de cualquier otro individuo con licencia o registrado con la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes médicos y acupunturistas, pueden ser reportados para investigación a la siguiente dirección:)*

Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P. O. Box 2018, MC-263
Austin, Texas 78768-2018
1-800-201-9353

GENERAL INFORMATION
HOSPITAL PARA NIÑOS "TEXAS SCOTTISH RITE"

HISTORY

In 1921, there was an urgent need in Texas to help the victims of polio, then the leading cause of disability among children. This need was recognized and met by a group of dedicated Texas Scottish Rite Masons and W.B. Carrell, M.D., the first orthopaedic surgeon in Dallas. Texas Scottish Rite Hospital for Children was founded to support the care and treatment of these children.

With the welcomed advent of the Salk and Sabin vaccines in the mid-1950s and the almost total disappearance of polio, the Hospital was able to redirect its efforts to the treatment of musculoskeletal deformities resulting from birth defects, accidents and diseases. More recently, the Hospital has expanded its services to include the diagnosis and treatment of certain related neurological disorders and learning disorders, such as dyslexia.

The Hospital, which is accredited by The Joint Commission, offers both inpatient and outpatient services to an active patient roster of more than 15,000 children.

(HISTORIA)

En 1921, en Texas había una necesidad urgente para ayudar a las víctimas de polio, que para aquel entonces, era la causa primordial de incapacidades entre los niños. Esta necesidad fue reconocida y cumplida por un grupo dedicado de Masones del "Texas Scottish Rite" y por W. B. Carrell, M.D. el primer cirujano ortopédico en Dallas. El Hospital para Niños "Texas Scottish Rite" fue fundado para ofrecer el cuidado y tratamiento de estos niños.

Con la bienvenida de las vacunas de Salk y Sabin a mediados del 1950 y la casi desaparición en su totalidad del polio, el hospital tuvo la oportunidad de redirigir sus esfuerzos al tratamiento de deformidades músculo-esqueléticas como resultado de los defectos de nacimiento, accidentes y enfermedades. Más recientemente, el Hospital ha extendido sus servicios para incluir el diagnóstico y tratamiento de varios trastornos neurológicos y aprendizaje relacionados, tales como dislexia.

El Hospital, el cual está acreditado por la Comisión Conjunta ofrece servicios para pacientes internos y ambulatorios a un listado de pacientes activos de más de 15,000 niños.

WHAT CONDITIONS DOES THE HOSPITAL TREAT?

The Hospital's primary objective is the treatment of children with orthopaedic conditions. These include conditions such as scoliosis, clubfoot, dislocated hips, Legg-Perthes, congenital and traumatic limb loss, arthritis, spina bifida, and the orthopedic after-effects of cerebral palsy, encephalitis, meningitis and accidental injury. The Hospital's Luke Waites Center for Dyslexia and Learning Disorders provides evaluation of children, ages 5 through 14, with suspected academic learning disorders.

¿PARA QUÉ CONDICIONES OFRECE TRATAMIENTO EL HOSPITAL?

El objetivo primordial del hospital es tratamiento para niños con problemas ortopédicos. Estos incluyen condiciones, tales como, escoliosis, pie zambo, caderas dislocadas, enfermedad de "Legg-Perthes", la pérdida de una extremidad, ya sea congénita o traumática, artritis, espina bífida, problemas ortopédicos causados después de una parálisis cerebral, encefalitis, meningitis y lesiones accidentales. El Centro de Dislexia y Problemas del Aprendizaje

"Luke Waites" del Hospital ofrece evaluaciones para niños entre las edades de 5 a 14 años donde se sospecha que puedan tener algún trastorno para el aprendizaje académico.

WHO PROVIDES THIS CARE?

The Hospital's clinical staff are recognized as some of the best in their fields. This includes physicians in the specialties of pediatric orthopaedics, neurology, developmental disabilities, learning disorders, anesthesiology, rheumatology, and radiology. Working with the medical and nursing staff to provide comprehensive patient care are orthotists, prosthetists, psychologists, learning assessment specialists, social workers, child life specialists, and physical and occupational therapists.

¿QUIÉN PROPORCIONA ESTE CUIDADO?

El personal clínico del Hospital está reconocido como uno de los mejores en su área. Esto incluye los médicos especializados en pediatría ortopédica, neurología, problemas del desarrollo, problemas del aprendizaje, anestesiología, reumatología y radiología. Trabajando con el personal médico y de enfermería para ofrecerle un cuidado completo al paciente, están los ortésicos, protésicos, psicólogos, especialistas de valoración del aprendizaje, trabajadores sociales, especialistas en la vida del niño y terapeutas físicos y ocupacionales.

WHAT ARE THE REQUIREMENTS FOR A CHILD TO BE TREATED AT THE HOSPITAL?

1. The child's condition should offer hope of improvement through the services provided by the Hospital.
2. The child can be up to 18 years of age, except for Luke Waites Center for Dyslexia applicants who must be between the ages of 5 and 14 years.
3. The child must be a Texas resident.
4. A physician's referral is required for each patient application.
5. Since many Masons recommend patients for treatment, the patient application form includes a space for a Mason's signature. However, if no Mason was involved in the referral, we will secure a signature as necessary

¿CUÁLES SON LOS REQUISITOS PARA QUE UN NIÑO SEA TRATADO EN EL HOSPITAL?

1. *La condición del niño debe ofrecer esperanza de mejoramiento a través de los servicios proporcionados por el Hospital.*
2. *El niño debe ser menor de 18 años de edad, con la excepción de los que solicitan la evaluación del Centro de Dislexia "Luke Waites", quienes deben estar entre las edades de 5 a 14 años de edad*
3. *El niño debe ser residente del estado de Texas.*
4. *Se requiere un referido médico para cada paciente que solicita.*
5. *Debido a que muchos Masones recomiendan pacientes para recibir tratamiento, el formulario de la solicitud para el paciente incluye un espacio para la firma del Masón. Sin embargo, de no tener el referido de un Masón, nosotros obtendremos la firma tal como fuera necesario.*

WHAT TYPES OF CASES ARE NOT ELIGIBLE?

To assure appropriate use of Hospital resources, applications will not be approved for children who:

- need only prolonged nursing care, respite care and/or residential care;
- cannot benefit from the specialized treatment or learning disorder evaluation offered at the Hospital;
- have conditions for which the Hospital is not able to provide treatment ; or
- need emergency services due to accidental injury or acute illness

The Hospital is open to children of all races, colors and creeds. The decision to accept a patient for treatment is based solely on the above criteria, with no consideration of the financial resources of the family. If the hospital cannot provide treatment, our staff will attempt to assist the family to find appropriate care for their child.

¿QUÉ TIPO DE CASOS NO SON ELEGIBLES?

Para asegurar el uso apropiado de los recursos del Hospital, no serán aprobadas aquellas solicitudes para niños que:

- *solamente necesitan atención médica prolongada, cuidado de descanso y/o cuidado en el hogar;*
- *no puedan beneficiarse del tratamiento especializado o una evaluación para trastorno del aprendizaje ofrecido por el*

Hospital;

- *tienen condiciones, las cuales el Hospital no puede proporcionar tratamiento; o*
- *necesitan servicios de emergencia debido a una lesión accidental o enfermedad severa*

El Hospital está disponible para niños de todas razas, colores y religiones. La decisión de aceptar a un paciente para tratamiento está sujeto a solamente a los criterios establecidos con anterioridad, sin consideración alguna sobre los recursos financieros de la familia. Si el hospital no puede proporcionar tratamiento, nuestro personal tratará de asistir a la familia a encontrar el cuidado apropiado para su niño.

HOW DOES A CHILD BECOME A PATIENT AT TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN?

Physicians can refer a patient by calling the Patient Access number listed below or by completing and signing the medical information portion of the application. The remainder of the application should be completed and signed by the parents or legally responsible person(s), thus giving their approval for an evaluation by the hospital's medical staff.

All referrals and applications are reviewed by Hospital staff when received. If the child is eligible for services, an appointment will be given, and a written notice will be sent to the parents/legally responsible persons as well as to the referring physician.

MAIL COMPLETED APPLICATION AND PHYSICIAN REFERRAL TO:

Patient Access Department
Texas Scottish Rite Hospital for Children
2222 Welborn Street
Dallas, Texas 75219-9982

FOR MORE INFORMATION, PLEASE CALL:
Daytime Business Hours: (214) 559-7477
After Hours: (214) 559-5000

¿CÓMO UN NIÑO PUEDE LLEGAR A SER PACIENTE DEL HOSPITAL PARA NIÑOS "TEXAS SCOTTISH RITE"?

Los médicos pueden referir a un paciente llamando al número listado más adelante como: "Patient Access" (Acceso al Paciente) o completando la sección de información médica en la solicitud y firmando la misma. La información restante de la solicitud debe ser completada y firmada por los padres o tutores legales responsables del niño, dando así su aprobación para que el personal médico del hospital pueda proceder con una evaluación médica.

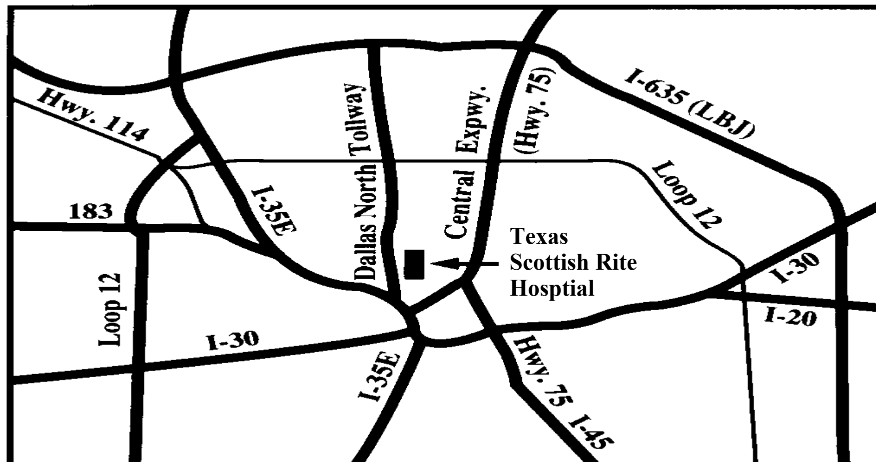
Todas las solicitudes y los referidos son evaluados por personal médico del Hospital una vez son recibidos. Si el niño es elegible para servicios, se le dará una cita y una notificación por escrito será enviada a los padres/las personas legalmente responsables, al igual que al médico que está refiriendo al paciente.

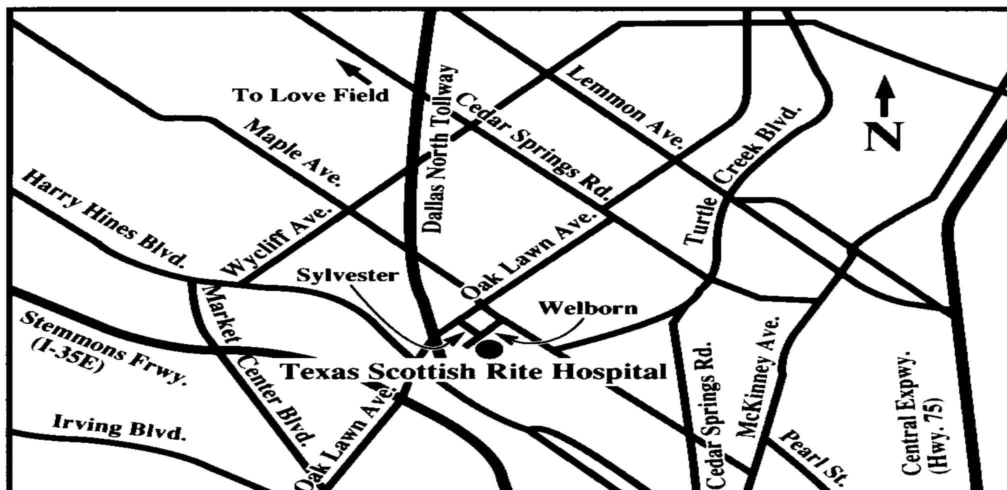
ENVÍE POR CORREO LA SOLICITUD COMPLETA Y EL REFERIDO DEL MÉDICO A:

Patient Access,
Texas Scottish Rite Hospital for Children
2222 Welborn Street
Dallas, Texas 75219-9982

PARA INFORMACIÓN ADICIONAL, FAVOR DE COMUNICARSE:

Horas de oficina durante el día: (214) 559 7477
Después de horas de oficina: (214) 559 5000





TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
2222 WELBORN STREET
DALLAS, TX 75219

Luke Waites Center for Dyslexia and Learning Disorders

REQUIRED SCHOOL RELATED INFORMATION

Child's Name: ____ Date: ____________________________

Dear Parent/Guardian:

The primary mission of the center is to evaluate children's learning in order to identify learning disorders, to educate parents about the educational needs of their child, and to support partnering with educators to provide an appropriate educational plan.

Our center is able to evaluate children ages 5 through 14 years of age who are proficient in the English language. We are unable to provide services to children whose learning difficulty is only due to:

- Low cognitive ability
- Attention problems
- Emotional/behavioral problems
- Autism or Pervasive Developmental Disorders
- Hearing or Vision Impairment

We are pleased that you are considering the services of the Luke Waites Center for Dyslexia and Learning Disorders. In order to process your application, please send **ALL** of the information requested below:

_____ 1. Patient Referral Information Application

_____ 2. Luke Waites Center for Dyslexia Application

_____ 3. Academic Checklist - Teacher Form

_____ 4. Copies of Custody Papers, if applicable

_____ 5. Required School Related Information (See page 2)

WE WILL BE UNABLE TO PROCESS YOUR CHILD'S APPLICATION UNTIL ALL COMPLETED INFORMATION HAS BEEN RECEIVED. Please call our office at 214-559-7815 if you have questions about the requested information.

Mail Completed Application To:

Texas Scottish Rite Hospital for Children
Patient Access Department
2222 Welborn Street
Dallas, TX 75219-9982

Visit us online at: https://scottishritehospital.org/becoming-our-patient for additional information.

TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
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DALLAS, TX 75219

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If your child does not attend a traditional public or private school, we will send you supplemental home school documents to complete as a part of the application process.

If your child attends a traditional public or private school, below is a list of information your child may have. **Please ask your child's school counselor or other school personnel to help provide the information.**

Reading Readiness & Progress Monitoring Tests

- ☐ TPRI *(Texas Primary Reading Inventory)*
- ☐ ISIP *(iStation Indicators of Progress)*
- ☐ DIBELS *(Dynamic Indicators of Basic Early Literacy Skills)*
- ☐ AIMSweb
- ☐ DRA *(Developmental Reading Assessment*
- ☐ MAP *(Measures of Academic Progress)*

Public School or Private Evaluations

- ☐ FIE (Full and Individual Evaluation) including test scores
- ☐ ARD (Admission, Review and Dismissal) documentation
- ☐ Speech−Language Evaluation
- ☐ Psychological or Psycho−educational Evaluation
- ☐ Dyslexia Screening/Assessment

Group Administered Tests

- ☐ ITBS *(Iowa Test of Basic Skills)*
- ☐ CogAT *(Cognitive Abilities Test)*
- ☐ SAT *(Stanford Achievement Test)*
- ☐ TAKS *(Texas Assessment of Knowledge and Skills)*
- ☐ MAT *(Metropolitan Achievement Test)*
- ☐ STAAR *(State* of *Texas Assessments of Academic Readiness)*
- ☐ ISEE *(Independent School Entrance Exam)*

Language Proficiency Testing

- ☐ TELPAS *(Texas English Language Proficiency Assessment System)*
- ☐ WMLS *(Woodcock−Munoz Language Survey)*
- ☐ *Tejas Lee* OLPT *(Oral Language Proficiency Test)*

Educational Plans

- ☐ Section 504 Plan
- ☐ Student Success Team Intervention Plan
- ☐ Individualized Education Plan (IEP)

After your application and additional information are carefully reviewed, you will receive a letter regarding service eligibility for your child. We look forward to serving your child in the best possible way. If you have any questions, please contact the Luke Waites Center for Dyslexia and Learning Disorders at 214−559−7815.

WE WILL BE UNABLE TO PROCESS YOUR CHILD'S APPLICATION UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED

TEXAS SCOTTISH RITE HOSPITAL FOR CHILDREN
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COMPLETE THIS FORM ONLY IF YOU ARE REQUESTING AN EVALUATION FOR LEARNING DISORDERS

Child's Name: ____ Date of Birth:____________________________

School Name: _________________________________ School District: __________________________________

School Type: ☐ Public ☐ Public Charter ☐ Private ☐ *Home School ☐ University Model ☐ Virtual/Online

*If your child participates in home-based education, we will send you supplemental home school documents to complete

Grade: ________ Has your child repeated a grade? ☐ Yes ☐ No If yes, which grade? ______________________

If your child was adopted, how old was your child at adoption? ____________________

If adoption was international, where was your child born? ____

1) Does your child know and speak English? ☐ Yes ☐ No
2) If your child speaks more than one language, at what age did he/she begin to learn English? ________________
3) If your child speaks more than one language, what is his/her current level of English language proficiency, based on school testing? ☐ Beginning ☐ Intermediate ☐ Advanced ☐ Advanced High ☐ I don't know
4) What language is primarily spoken in the home? ______________________
5) **CHOOSE ONE:**
   - ☐ My child needs testing. There has been no individual educational or psychological testing at school or away from school.
   - ☐ My child **has** been tested and **is** getting special help at school. I need to know if the special services are appropriate for my child's needs.
   - ☐ My child **has** been tested but does **not** get special help at school. I would like a second opinion.
   - ☐ My child is being considered for a dyslexia program and needs an evaluation.
   - ☐ My child has been recognized with dyslexia and is participating in a dyslexia program. I need a specific diagnosis of dyslexia.
6) Is there a plan for your child to be tested at school or privately? ☐ Yes ☐ No
   If yes, When? _________________ For what reason? ____
7) **What are you concerned about?** Check all that apply.
   - ☐ Reasoning, Judgment
   - ☐ Speech/Articulation
   - ☐ Understanding and Expressing Spoken Language
   - ☐ Phonics/Learning Letter Sounds
   - ☐ Reading Sight Words
   - ☐ Reading Fluency
   - ☐ Reading Comprehension
   - ☐ Spelling
   - ☐ Handwriting
   - ☐ Writing Sentences
   - ☐ Writing Stories
   - ☐ Learning Numbers
   - ☐ Applying Math
   - ☐ Argues
   - ☐ Gets in Trouble
   - ☐ Extreme Temper Tantrums or Meltdowns
   - ☐ Distractibility
   - ☐ Concentration
   - ☐ Focus
   - ☐ Hyperactivity
   - ☐ Sadness
   - ☐ Worry
   - ☐ Mood/Irritability
   - ☐ Suicidal Statements and Thoughts
   - ☐ Social Skills
   - ☐ Bullying
   - ☐ PDD/Autism Spectrum Disorder
   - ☐ Vision: Explain ____
   - ☐ Hearing: Explain ____

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8) Which **one** of these are you most concerned about? **Check ONE only**.

- ☐ Reasoning, Judgment
- ☐ Speech/Articulation
- ☐ Understanding and Expressing Spoken Language
- ☐ Phonics/Learning Letter Sounds
- ☐ Reading Sight Words
- ☐ Reading Fluency
- ☐ Reading Comprehension
- ☐ Spelling
- ☐ Handwriting
- ☐ Writing Sentences
- ☐ Writing Stories
- ☐ Learning Numbers
- ☐ Applying Math

- ☐ Argues
- ☐ Gets in Trouble
- ☐ Temper/Anger Control
- ☐ Distractibility
- ☐ Concentration
- ☐ Focus
- ☐ Hyperactivity
- ☐ Social Skills

- ☐ Sadness
- ☐ Worry
- ☐ Mood/Irritability
- ☐ Suicidal Statements & Thoughts
- ☐ PDD/Autism Spectrum Disorder

- ☐ Vision
- ☐ Hearing

9) Check **all** services or programs your child **is receiving** or **has received** in the past. (You may need to ask your child's teacher to help if you're not sure.)

- ☐ Speech Therapy
- ☐ Oral Language Therapy
- ☐ Occupational Therapy
- ☐ Tutoring
- ☐ RtI
- ☐ Dyslexia Class
- ☐ Academic Language Therapy
- ☐ Section 504 Plan
- ☐ Special Education
- ☐ ESL
- ☐ Bilingual Education
- ☐ Spanish Immersion
- ☐ Dual Language Program
- ☐ ECI and/or PPCD
- ☐ Other: ____________________

10) Have you ever had a school meeting to discuss? (check all that apply)

- ☐ Special Education Eligibility
- ☐ Dyslexia Testing
- ☐ Section 504 Plan
- ☐ Private School Specialized Instruction or Accommodation Plan

If yes, when? ____________________

11) In what area is your child being served through special education?

- ☐ Speech Impairment (SI)
- ☐ Specific Learning Disability (SLD)
- ☐ Intellectual Disability (ID)
- ☐ Auditory Impairment (AI)
- ☐ Visual Impairment (VI)
- ☐ Emotional Disturbance (ED)
- ☐ Other Health Impaired (OHI)
- ☐ Does Not Apply
- ☐ Other: ____________________

12) Does your child have a history of delay in language and speech development? ☐ Yes ☐ No
If yes, please describe: ____________________

____

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13) What mental health diagnosis does your child have? ____ ☐ None

14) Has your child seen a neurologist? ☐ Yes ☐ No Name: ____

If yes, why? ____

15) Has your child seen a psychiatrist? ☐ Yes ☐ No Name: ____

If yes, why? ____

16) Has your child seen a private counselor? ☐ Yes ☐ No Name: ____________________________________

If yes, why? ____

17) Has your child seen a doctor about any of the following? ☐ Yes ☐ No

☐ Attention Problem ☐ Negative behavior ☐ Anxiety ☐ Depression

If yes, what was the outcome? ____

18) Has your child taken medicine to help with the following? ☐ Yes ☐ No

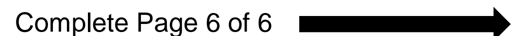
☐ Attention Problem ☐ Negative behavior ☐ Anxiety ☐ Depression

If yes, what medicine(s)? ____

When did your child first take the medicine? Month: _____________________ Year: _________________

Does your child still take this medicine? ☐ Yes ☐ No

Complete Page 6 of 6



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Child's Name: ____ Date of Birth: ___________________________

19) WHAT MEDICAL DIAGNOSIS DOES YOUR CHILD HAVE?

- ☐ ADHD/ADD *ADHD/ADD*
- ☐ Allergies *Alergias*
- ☐ Angelman Syndrome *Sindrome de Angelman*
- ☐ Anxiety Disorder *Transtorno de Ansiedad*
- ☐ Asperger's Syndrome *Sindrome de Asperger*
- ☐ Asthma *Asma*
- ☐ Attachment Disorder *Transtorno de Apego*
- ☐ Autism Spectrum Disorder *Autismo*
- ☐ Bipolar Disorder *Transtorno Bipolar*
- ☐ Blindness *Ceguera*
- ☐ Bone Problems *Problemas óseos*
- ☐ Cerebral Palsy *Parálisis Cerebral*
- ☐ Cleft Palate/Cleft Lip *Paladar Hendido/Labio Leporino*
- ☐ Diagnosed Concussion *Concusión*
- ☐ Conduct Disorder *Transtorno de Conducta*
- ☐ Congenital Heart Surgery *Cirugía Cardíaca Congénita*
- ☐ Deafness *Sordera*
- ☐ Depression *Depresión*
- ☐ Diabetes *Diabetes*
- ☐ Down Syndrome *Sindrome de Down*
- ☐ Dwarfism *Enanismo*
- ☐ Encopresis *Encopresis*
- ☐ Enuresis *Enuresis*
- ☐ Fetal Alcohol Syndrome *Sindrome de Alcohol Fetal*
- ☐ Fragile X *X Frágil*
- ☐ Galactosemia *Galactosemia*
- ☐ History of Cancer *Historial de Cáncer*
- ☐ History of Meningitis *Historial de Meningitis*
- ☐ Hospitalization for Drowning *Hospitalización por Ahogamiento*
- ☐ History of Stroke *Historial de Embolia*
- ☐ HIV *VIH*
- ☐ Intellectual Disability/Mental Retardation *Discapacidad Intelectual/Retrasco Mental*
- ☐ Irritable Bowel Syndrome *Sindrome de Colon Irritable*
- ☐ Kleinfelter's Syndrome *Sindrome de Kleinfelter*
- ☐ Muscular Dystrophy *Distrofia Muscular*
- ☐ Neurofibromatosis *Neurofibromatosis*
- ☐ Obsessive Compulsive Disorder *Trastorno Compulsivo Obsesivo*
- ☐ Oppositional Defiant Disorder *Trastorno de Oposición Desafiante*
- ☐ Pervasive Developmental Disorder *Autismo y Trastorno Generalizado del Desarrollo*
- ☐ Phenylketonuria *Fenilcetonuria*
- ☐ Prader Willi Syndrome *Sindrome de Prader Willi*
- ☐ Seizure Disorder *Trastornos Convulsivas*
- ☐ Selective Mutism *Mutismo Selectivo*
- ☐ Sickle Cell Anemia *Anemia Perniciosa*
- ☐ Sickle Cell Trait *Caracteristicas de Anemia*
- ☐ Spina Bifida *Espina Bifida*
- ☐ Thyroid Disorder *Trastorno de la Tiroides*
- ☐ Tic Disorder *Trastornos de Movimientos Involuntarios*
- ☐ Tourette Syndrome *Sindrome de Tourette*
- ☐ Diagnosed Traumatic Brain Injury *Lesion Cerebral Traumática*
- ☐ Tuberous Sclerosis *Esclerosis Tuberosa*
- ☐ Turner's Syndrome *Sindrome de Turner*
- ☐ William's Syndrome *Sindrome de William*
- ☐ Other: ___________________________ *Otro:* ___________________________
- ☐ None *Ninguna*