CHILD PATIENT REGISTRATION & SUPPORT APPLICATION

Tigawa International Children's Heart Foundation Africa (TICHFA AFRICA INC.)

For pediatric cardiac care referrals, care navigation, potential financial assistance, and family support. Completing this form does not guarantee enrollment, funding, transport, medical treatment, or a hospital appointment.

1 Application information

Application date _____

Application / case ID (office use) _____

Country and city of residence _____

Preferred language / interpreter needed

_____

Request type: ☐ First application ☐ Update ☐ Referred by provider ☐ Other

2 Child information

Child's full legal name _____

Preferred name (optional) _____

Date of birth (DD/MM/YYYY) _____

Age _____

Sex (if clinically relevant) _____

Nationality _____

Country / city / district _____

Parent/guardian address _____

Does the child have a passport? ☐ Yes ☐ No ☐ In process

3 Parent / legal guardian

Guardian full legal name _____

Relationship to child _____

Phone / WhatsApp (with country code)

_____

Email (optional) _____

Alternate emergency contact / phone _____

Guardian legal authority: ☐ Parent ☐ Court-appointed guardian ☐ Other (explain)

If guardian is not a parent, attach evidence of authority using a secure process if requested.

4 Medical needs — initial screening only

Do not send detailed records or photographs through ordinary email. Staff will provide a secure method if clinical documents are required.

Known heart diagnosis (if known) _____

Treating clinic / hospital and country _____

Treating clinician / contact (if known)

_____

Date of most recent cardiac evaluation

_____

Main support requested _____

Prior heart surgery? ☐ Yes ☐ No ☐ Unknown

Current hospital admission? ☐ Yes ☐ No

Does the child need urgent medical care now? ☐ Yes ☐ No ☐ Unsure

IMPORTANT: This form is NOT an emergency service. If the child has severe breathing difficulty, fainting, blue lips, or other urgent symptoms, seek local emergency medical care immediately.

5 Services requested

Select all that apply: ☐ Specialist referral ☐ Medical coordination ☐ Surgery funding inquiry

Additional services: ☐ Medical travel guidance ☐ Family support ☐ Transport inquiry ☐ Other

6 Financial and practical needs (optional)

Estimated cost / currency (if known) _____

Amount family can contribute (optional)

_____

Insurance / government assistance (optional)

_____

Travel or lodging challenges (optional)

_____

Permission to contact about possible sponsorship opportunities? ☐ Yes ☐ No

7 Referral details (if applicable)

Referring organization / clinician _____

Contact phone or email _____

How did you hear about TICHFA? _____

8 Parent / guardian declarations

By signing, I confirm that I am the child's parent or authorized legal guardian, and that the information supplied is accurate to the best of my knowledge. I understand that TICHFA may contact

me to review eligibility and discuss available services, and that TICHFA does not itself promise or perform surgery, provide emergency care, or guarantee funding.

I understand that medical decisions remain with licensed treating professionals. Participation is voluntary, and I may request to stop non-emergency support at any time, subject to legal and operational requirements.

I agree to be contacted about this application: ☐ Yes ☐ No

Guardian printed name _____

Guardian signature _____

Date / place _____

9 Privacy and information sharing

TICHFA will use information provided here to assess and coordinate requested support, subject to applicable privacy laws. A separate privacy notice should explain collection, storage, security, retention, and contact rights. This application is not a HIPAA authorization, medical-record release, treatment consent, or permission to publish the child's story or photo.

I received or was offered the applicable privacy notice: ☐ Yes ☐ No

Any disclosure requiring specific authorization, including certain transfers to hospitals or international partners, must be handled through a separate appropriate authorization. Consent to media use or fundraising publicity is entirely separate and optional.

10 Office use only — staff assessment

Received by / date _____

Case reference / secure document location

_____

Initial eligibility screening _____

Missing documents / follow-up actions

_____

Referral / next review date _____

Assigned case coordinator _____

Application status: ☐ Received ☐ Needs information ☐ Under review ☐ Referred ☐ Closed

Do not record detailed medical notes in this form unless approved secure recordkeeping procedures are in place.

Contact: +1 855-441-4555 (toll-free) | +1 603-704-3756 | +1 617-291-6821 | +1 614-571-9333 | +256 701 238 006

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DRAFT FOR LEGAL / PRIVACY REVIEW BEFORE OPERATIONAL USE. Verify registration, actual services, offices, and applicable U.S./Ugandan/international requirements.