CHILD PATIENT REGISTRATION & INTERNATIONAL CARE APPLICATION

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

Every Child Deserves a Healthy Heart. | www.tichfa.org | info@tichfa.org

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For guardian completion. Use N/A when not applicable; do not send completed forms or medical records through unsecured email. Registration does not guarantee financial support, hospital admission, visas, transport, or treatment.

1. Application & Patient Identity

Application ID (office use): _____

Date of application (DD/MM/YYYY): _____

Child full legal name (as on passport): _____

Preferred name / initials: _____

Date of birth (DD/MM/YYYY): _____

Age: _____

Country of birth: _____

Nationality / citizenship: _____

Current country and residential address:

_____

District / province / postal code: _____

Primary language / interpreter needed: _____

Sex (optional): ☐ Female ☐ Male ☐ Prefer not to say ☐ Self-describe

National identification / birth certificate number (if applicable):

_____

2. Parent / Legal Guardian & Custody

Guardian full legal name: _____

Relationship to child: _____

Phone / WhatsApp: _____

Email: _____

Home address (if different): _____

Second guardian name and contact (if applicable):

_____

Legal custody / guardianship documentation reference:

_____

Legal authority to consent for child: ☐ Parent ☐ Court-appointed guardian ☐ Other (explain)

Interpreter needed for guardian: ☐ Yes ☐ No

3. Next of Kin & Emergency Contacts

Next of kin full name: _____

Relationship: _____

Primary phone / WhatsApp: _____

Alternate phone: _____

Email: _____

Full address: _____

Emergency contact 2 name and relationship:

_____

Emergency contact 2 phone: _____

Person authorized to accompany child (name / relationship):

_____

4. Passport, Visa & International Travel Documents

Complete for the child AND each traveling guardian/companion. Keep original documents secure; do not include document scans unless requested via a secure channel.

CHILD

Full name as on travel document: _____

Passport / travel document number: _____

Issuing country / authority: _____

Issue date (DD/MM/YYYY): _____

Expiry date (DD/MM/YYYY): _____

Visa number / reference (if issued): _____

Visa type / destination country: _____

Visa issue date: _____

Visa expiry date: _____

Immigration / residency permit number and expiry (if relevant):

_____

ACCOMPANYING ADULT 1

Full name as on travel document: _____

Passport / travel document number: _____

Issuing country / authority: _____

Issue date (DD/MM/YYYY): _____

Expiry date (DD/MM/YYYY): _____

Visa number / reference (if issued): _____

Visa type / destination country: _____

Visa issue date: _____

Visa expiry date: _____

Immigration / residency permit number and expiry (if relevant):

_____

ACCOMPANYING ADULT 2 (if any)

Full name as on travel document: _____

Passport / travel document number: _____

Issuing country / authority: _____

Issue date (DD/MM/YYYY): _____

Expiry date (DD/MM/YYYY): _____

Visa number / reference (if issued): _____

Visa type / destination country: _____

Visa issue date: _____

Visa expiry date: _____

Immigration / residency permit number and expiry (if relevant):

_____

Passport currently valid: ☐ Yes ☐ No ☐ Pending renewal

Medical travel visa status: ☐ Not applied ☐ Applied ☐ Approved ☐ Denied ☐ Not required

Planned destination country / hospital: _____

Expected travel dates: _____

Child travel consent / custody clearance reference:

_____

Vaccination or entry document reference (if applicable):

_____

5. Clinical & Medical History (guardian-reported; clinician verification required)

Primary cardiac diagnosis / suspected diagnosis:

_____

Date diagnosed: _____

Referring physician name, specialty, contact:

_____

Current hospital / clinic and medical record number:

_____

Primary pediatrician and contact: _____

Treating cardiologist / surgeon and contact:

_____

Prior hospital admissions and dates: _____

Previous cardiac procedures / surgery and dates:

_____

Current medications (name, dose, schedule):

_____

Medication allergies and reaction: _____

Other allergies: _____

Other chronic illnesses / conditions: _____

Relevant family cardiac history: _____

Immunization status (if clinically relevant):

_____

Height / weight / date measured (if available):

_____

Current care needs: ☐ Oxygen ☐ Feeding support ☐ Mobility assistance ☐ Other ☐ None reported

Urgent symptoms or deterioration: ☐ Yes—seek clinical assessment ☐ No ☐ Unknown

Symptoms, functional limitations, important medical history, and other special needs

_____

_____

_____

6. Medical Records Checklist (do not attach originals)

Available documents: ☐ Cardiology report ☐ Echocardiogram ☐ ECG ☐ Chest X-ray ☐ CT/MRI ☐ Lab results

Additional records: ☐ Discharge summary ☐ Operative report ☐ Medication list ☐ Referral letter ☐ Vaccination record ☐ Other

Dates of most recent reports: _____

Records held by (hospital/clinician): _____

Secure records transfer method / contact:

_____

Records language and translation required:

_____

7. Requested Services & Treatment Plan

Requested assistance: ☐ Specialist referral ☐ Surgery assessment ☐ Funding inquiry ☐ Medical travel coordination

Additional assistance: ☐ EMS / ground transport inquiry ☐ Accommodation ☐ Family support ☐ Follow-up coordination

Proposed hospital / destination: _____

Requested procedure or evaluation (if known):

_____

Referring clinician recommendation date:

_____

Estimated medical cost and currency: _____

Estimated travel / accommodation cost and currency:

_____

Expected timeline / clinical priority (per clinician):

_____

Family's goals and additional support needs

_____

_____

8. Financial & Sponsorship Assessment (optional)

Primary household income range / currency:

_____

Number of household dependents: _____

Insurance provider / policy reference (optional):

_____

Insurance coverage / exclusions (if known):

_____

Existing financial support / sponsor: _____

Amount requested and currency: _____

Permission to contact regarding support options: ☐ Yes ☐ No

9. Privacy, Consent & Declaration

This application gathers sensitive personal and medical information. TICHFA should provide an applicable privacy notice and secure collection/storage procedures before intake. This application is NOT a HIPAA authorization, medical treatment consent, medical travel consent, or permission to publish a child's story or photo. Separate forms are required when applicable.

Guardian confirms information is accurate to best of knowledge: ☐ Yes

Guardian requests TICHFA to review this application and contact them: ☐ Yes ☐ No

Guardian received / was offered applicable privacy notice: ☐ Yes ☐ No ☐ Not yet

Guardian printed name: _____

Guardian signature: _____

Signature date: _____

Interpreter / witness name and signature (if used):

_____

10. Internal Review — TICHFA Staff Only

Received by / date: _____

Case ID (use instead of patient name in routine tracking):

_____

Required records missing: _____

Clinical referral status: _____

Passport / visa expiry follow-up needed: _____

Safeguarding / confidentiality escalation (if any):

_____

Assigned coordinator: _____

Next review date: _____

Application status: ☐ Incomplete ☐ Under review ☐ Referred ☐ On hold ☐ Closed

Clinical decisions must be made by licensed medical professionals. In an emergency, contact local emergency services or the nearest emergency department. Verify the organization's operational services and regulatory permissions before using this form.