OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

Serious Medical Procedure Request (SMR) Form
Unaccompanied Children's Program
Office of Refugee Resettlement (ORR)

Care Provider Program Staff,
Non-emergent serious medical/dental procedures/services require advance approval from the ORR Director. Note: this form is not required for emergency procedures, procedures performed during hospitalization, or procedures resulting from complication of a previously approved procedure.

The form should be completed for the following non-emergent services:

- Procedures requiring general anesthesia
- Surgeries
- Invasive diagnostic procedures (e.g., cardiac catheterization, invasive biopsy, amniocentesis)

Program staff must complete page 1 and ask the healthcare provider who will perform the procedure/service to complete pages 2 and 3. Date fields should be completed in month/day/year format. Email the entire request packet to the Division of Health for Unaccompanied Children (DHUC) at DCSMedical@acf.hhs.gov. Enter and upload all documentation to the child's record in the Health tab of UAC Path. DHUC requires at least 72 business hours to review the completed request packet.

IMPORTANT: This completed form must be submitted and approved BEFORE the appointment for the procedure/service is made. Procedures/services performed in advance of approval are subject to non-payment and will become the responsibility of the care provider program if the procedure/service is denied. You will be notified of approval or denial via email or phone. If the procedure/service is approved, submit a Treatment Authorization Request (TAR) form through PCU.

Program Information		
Program name:		**Date submitted:**
POC:	**Email address:**	**Phone #:**

Child Information		
Name:		**DOB:**
A#:	**Country of origin:**	**Intake date:**
Relationship of sponsor or type of release placement (e.g., mother, URM program, ICE custody), if known:		
City and state of sponsor/release placement:		

Estimated date of discharge if this procedure is not performed: ______ / ______ / _______	**Estimated date of discharge if this procedure is performed:** ______ / ______ / _______
Status of Family Reunification Packet:	

Referring healthcare provider:	**Clinic**	**City and State**	**Phone #**

Comments/Additional Info

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Dear Colleague,
The minor for whom you have recommended a procedure is an unaccompanied child in the custody of the Office of Refugee Resettlement (ORR) in the Department of Health and Human Services (DHHS). As such, ORR must collect specific information in order to assess and approve the procedure. While in ORR custody, the minor is placed in a government-funded program that is responsible for providing the day-to-day care of the minor. The ultimate goals of ORR are to ensure the health and safety of the minor while in custody and to unify the minor with his/her sponsor, as soon as possible. Please provide the requested information below, completely and clearly, and return to the program staff, along with the medical/consult notes indicating the need for the procedure/service. Please contact the Division of Health for Unaccompanied Children (DHUC) with any questions or concerns, DCSMedical@acf.hhs.gov. Thank you.

Details of Recommended Procedure

Diagnosis and clinical indications for performing surgery/procedure:

Potential risks of surgery/procedure:

Benefits of surgery/procedure:

From a health perspective, within how many days/weeks/months must surgery/procedure occur?

Potential adverse outcomes or complications if surgery/procedure is not done within recommended timeframe:

On what date can the surgery/procedure be scheduled? ________ / _______ / _________	**Estimated number of days in hospital:**

Diagnosis CPT code: ____
Procedure CPT code: ____

Post-Operative/Procedural Follow-up Care

Timeframe for follow-up appointment: _________ days	**Expected number of days after surgery/procedure until minor is medically cleared to travel by air or ground?** _________

Please include clinical notes that detail post-operative care needs (e.g., medications, physical/occupational therapy, durable medical equipment, physical/dietary restrictions)

Points of Contact

Hospital/Clinic:		**City/Town:**
Clinical Liaison:	**Email:**	**Phone #:**
Surgical Admin Liaison:		**Phone #:**
Hospital Admin Liaison:		**Phone #:**
Other, specify:		**Phone #:**

Comments/Additional Info
Healthcare Provider Signature: ____________________   **Healthcare Provider Printed Name:** ____________________   **Date:** _______ / ______ / __________

The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR. Public reporting burden for this collection of information is estimated to average 13 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279: Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996]). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0XXX and the expiration date is XX/XX/XXXX. If you have any comments on this collection of information, please contact UACPolicy@acf.hhs.gov.