

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

Dear Colleague,

The child for whom you have recommended a procedure is an unaccompanied alien child in the care of the Department of Health and Human Services (DHHS) Office of Refugee Resettlement (ORR). ORR places children in government-funded care programs to ensure their health and safety until they can be unified with a vetted sponsor. ORR is responsible for the provision of appropriate health care to children while they are in federal care. Serious medical/dental procedures require a higher level of scrutiny and approval, including review by ORR's Division of Health (DoH). The purpose of this form is to collect the information needed to complete this review process. ORR respects parents' and legal guardians' right to make medical decisions for their child. If a parent or guardian is not available, an ORR authorized official may give consent only if state law and licensing rules allow it. A child may consent for surgery/procedure if you - the treating healthcare provider - determine that child is eligible to provide informed consent in accordance with state laws and licensing requirements. Note, ORR requires that all evaluations/discussions with a child and their authorized consentor occur in their preferred language. Please complete and return this form to the care program staff **within 2 business days**.

Thank you, ORR DoH (ORRDHUAC@acf.hhs.gov)

Patient/Procedure Information

Child's name:	DOB: ____ / ____ / ____
Diagnosis(es):	
Procedure name(s):	
If surgery/procedure will occur in multiple stages, list each stage, included anticipated sequence and timing:	
Purpose/Indication(s) for surgery/procedure:	
Anesthesia type (e.g., general endotracheal, deep sedation): _____	
Date of Procedure (if known:) ____/____/____ or recommended timeframe (weeks): _____	
Setting: • Same day surgery • Planned hospital admission and anticipated duration if admitted: _____ days	
Risks of procedure(s), including risks of anesthesia if known:	
Risks of NOT having procedure(s):	

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: 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 0.17 hours per respondent, 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 (see, 45 CFR §§410.1306(g);410.1307). 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 0970-0466 and the expiration date is **XX/XX/XXXX**. If you have any comments on this collection of information, please contact ORRDHUAC@acf.hhs.gov.

Postoperative Information

Anticipated timeframe for post-operative visit: _____ days / weeks • PRN

Anticipated restrictions and duration (e.g., heavy lifting, physical activity, dietary):

Additional anticipated postoperative plan of care (e.g., physical therapy, specialty care, DME) and timeframe:

Anticipated time after procedure when child will be clear to travel: _____ days / weeks / months

Specify qualifications on air travel: • Not applicable

Consent/Assent

Was informed consent obtained? • Not yet • Yes, specify date: ____ / ____ / _____,

Name of authorized consenter:

Relationship to child:

Was assent obtained from the child? • Not yet • Yes, specify date: ____ / ____ / _____ • Not applicable

Additional Information

Acknowledgment

I hereby confirm that the information that I have documented on this form is complete and accurate to the best of my ability. Furthermore, I agree to release all of the child's relevant health records to ORR, including but not limited to office notes, imaging results, and treatment plans to ensure continuity of care.

Signature: _____

Specialty: _____

Printed Name: _____

Date: ____ / ____ / ____