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**U.S. HUB PROGRAM**

###### WELCOME

Thank you for your interest in SpineHope and our U.S. Hub Program.

**ABOUT SPINEHOPE**

SpineHope envisions a world in which every child with a spinal deformity has the opportunity to lead a normal life. We aim to transform children’s lives worldwide through surgery, education, and research.

SpineHope provides spine surgery children who otherwise would not receive this necessary care. Since 2001, our volunteer medical team has visited Latin America to partner with local doctors to correct spinal deformities, remove pain, prevent paralysis, and extend life.

Integral to our mission, we are dedicated to collaborative medical training and coaching with our U.S. team and Latin American partners, as well as sharing our experience of these complex surgeries with the international medical community via research.

The goal of the U.S. Hub Program is to offer this opportunity for medically necessary spine surgery to children who are not within our current international sites and to raise awareness and support within the U.S.

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###### PATIENT SELECTION GUIDELINES

###### The SpineHope Medical Advisory Committee, consisting of qualified medical professionals, will review potential cases. Cases will be accepted based on the following:

* Age 2-21 years
* Any deformity or pathology of the cervical, thoracic, or lumbar spine or myelopathy, except lordosis
* Achieved development milestones (i.e. crawling, walking, talking, etc.)
* Able to walk
* Do not have cancer of any type or neoplasm
* Appropriate follow-up care pathway at home
* Urgency
* Demonstration of need

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**U.S. HUB PROGRAM**

**APPLICATION**

**Parent’s / Guardian’s Information: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship to Child: ☐ Mother ☐ Father ☐ Other: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth (month/day/year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (street, city, country, zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passport #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ U.S. Citizen? ☐Yes ☐No

Do you speak English? ☐ Not at all ☐ A little ☐ Basic conversation ☐ Fluent

**Physician’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (street, city, country, zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone / Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Full Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth (month/day/year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at application: \_\_\_\_\_\_\_\_☐ Male ☐ Female

Address (street, city, country, zip): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passport #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ U.S. Citizen? ☐Yes ☐No

☐ Age 2-21 years: \_\_\_\_\_\_\_\_\_\_\_

☐ Spinal diagnosis and degree of curve: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Achieved development milestones (i.e. crawling, walking, talking, etc.)

☐ Able to walk

☐ Does not have cancer of any type

☐ Does not have TB, malaria, or HIV/AIDS

**How did you hear about SpineHope?**

☐ Family ☐ Friend ☐ Physician ☐ Health Care Professional ☐ School ☐ Internet

☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL RELEASE, CONSENT, AND WAIVER**

I, the undersigned parent or guardian, understand that the scope of my relationship with SpineHope is limited to one-time medical care in the U.S.; no compensation is expected in return for services provided; and I am responsible for my child’s follow-up medical care in my home country.

I hereby consent and authorize medical treatment by SpineHope or such others that it may designate for patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date of birth – month/day/year: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_). I understand that the services received may include risks, including but not limited medical treatment (i.e. spine surgery and associated hospital care) as well as to travel to and from the U.S. and my home country. I hereby grant permission to have my child participate in SpineHope’s U.S. Hub Program and receive medical treatment, specifically spine surgery and other medically necessary services. I understand that in participating my child may sustain physical illness or injury (minimal, serious, or catastrophic) in connection with his / her surgery. I further acknowledge and understand that my child is assuming the risk of such illness or injury by his / her participation, and I further release SpineHope as well as its representatives and other participants, from any claims for personal illness or injury that my child may sustain during this episode of care. I further acknowledge and understand that I will be responsible for follow-up medical care and bills in my home country. With full acknowledgement of the above, I expressly assume the risk and choose for my child to participate in SpineHope’s U.S. Hub Program.

I hereby RELEASE AND FOREVER DISCHARGE SpineHope and its officers, directors, employees, volunteers, participants, agents, legal representatives, insurers, successors, and assigns from any and all claims, demands, damages, liabilities, and causes of action that I now have or may have in the future, whether known or unknown, of any nature, relating to or arising out of my selection with SpineHope whether or not due to SpineHope negligence, strict liability, or any other breach or fault. This includes but is not limited to, death, bodily injury, personal injury, property damage, loss or theft of property, economic loss, or any other damage, loss, or cost. I reaffirm that the above general release includes but is not limited to any and all claims, damages, demands, or causes of action arising out of or relating to said medical treatment.

SpineHope has permission to release the patient’s health information to any person or company that is involved in any manner related to the provision of services. I authorize use of the patient’s health information for scientific and educational purposes.

Further, I consent to SpineHope taking photographs, videos and other recording of my child and family members, and grant and convey to SpineHope all rights, titles, and interests in any and all such photographs, videos, images, and/or audio records of my child, family members, or our likeness or voices made by SpineHope in connection with me providing volunteer services.

I certify that I am the parent, legal guardian or authorized representative of the patient named above and that I am legally authorized to consent to the matters contained herein. I agree to provide documentation to confirm such relationship and to notify the SpineHope and other treating providers if there is any future change in this relationship.

By signing below, I acknowledge that I carefully have read this form, and know and understand the contents thereof. I acknowledge that I was given the opportunity to seek independent legal counsel on any and all matters herein before I signed this General Release, Consent and Waiver.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THANK YOU!**

Thank you again for your interest in SpineHope and for applying to the US Hub Program.

We are excited to review your application and will be in touch soon.

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**US HUB PROGRAM**

###### REQUIRED DOCUMENTATION

* Application
* General Release, Consent, and Waiver
* X-rays of cervical, thoracic, and lumbar spine
* MRIs of neuraxis (preferred, not needed)
* Medical history including but not limited to:
	+ - Documentation of concurrent medical condition or syndrome, medical limitations, allergies, name & dosage of medications, etc.
		- Proof of no TB, malaria, or HIV/AIDS
* Child’s birth certificate
* Passport for both parents (if available for both) and child.