UNIVERSITY of ROCHESTER MEDICAL CENTER

Pediatric Pulmonary

Name:
Date of Birth:
Insurance Plan:
ID #:
Guarantor:
Referral #:

MD Office Phone:
MD Office Fax:
MD Office E-mail: (optional):
Parent's Names:
Parent's Phone #:
<u>*Please attach growth chart*</u>

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Referring Physician:
Reason for Referral:

Specific clinical question:

Level of Urgency: **Very _____ Moderate _____ Mild ____**
If you need this patient seen <u>URGENTLY</u>, please have the referring provider contact our office to speak with one of the pediatric pulmonologists. Approximate waiting time for appt is about <u>6 weeks</u>.

Brief History of Problem:

Related Hospitalizations:

Other specialties involved in care:

History of treatments tried for this problem (medications, PT, OT, dietary, etc.):

Current Medications ***If office uses an electronic medical record system, please print and fax past and current medication and problem lists:***

Allergies:

Pertinent PMH/PSH:

Relevant vital signs and PE findings:

Pertinent labs or imaging—(P*lease attach copies of results and <u>advise patient/family to bring films</u>*):

<u>*Please attach growth chart*</u>

Thank You. **09/2011**