Texas Children's Hospital

Appointment Request and Clinical Triage Form

Pulmonary Clinic

Phone: 832-822-3327 Fax: 832-825-9034

TCH LABEL HERE

Preferred locations:

___ Clinical Care Center (6701 Fannin- Medical Ctr)
___ Clear Lake Health Ctr (940 Clear Lake City Blvd.)
___ Cy-Fair Health Center (11777 FM 1960W)
___ Kingwood Specialty Care (19298 W Lake Houston Pkwy)
___ Sugar Land Health Ctr (15400 SW Frwy)
___ The Woodlands Hospital (17580 I-45 South, The Woodlands, 77384 - I-45 & 242)
___ West Campus (18200 Katy Freeway- I-10 & Barker Cypress)

Date of Request:				
PATIENT INFORMATION (PLEASE PRINT)				
Last Name	First Name & MI	Age	Date of Birth	M/F
Street Address	City	State	Zip Code	

Translator needed? No ____ Yes____ Preferred Language: New TCH Patient? No ____ Yes ____/ TCH MR #

Tracheostomy Present? Yes____ No____ Ventilator Present? Yes____ No____ Other Special Needs? _____

Parent/Guardian(s) Name	Home Phone #	Work Phone #	Cell Phone #

REFERRING PHYSICIAN INFORMATION

Referring Physician Name:		Best time to reach physician:
Practice Contact:	Office Phone:	Office Fax:
Primary Insurance Carrier:		Phone Number:

If a insurance referral is needed, please fax to: 832-825-3072.

Type of Referral to Pulmonary: _____ Consultation OR ____ Management

Referring Issue: PLEASE check the reason for the referral and *send last clinic note and related diagnostic images/disks and lab reports.*
For TCPA, will refer to EPIC.

Diagnosis/Problem			
Asthma/Recurrent Wheezing		___ Confirmation of diagnosis ___ Inadequate disease control Life Threatening Asthma: ___ Past ICU ___ Past Intubation ___ # of Visits ED/Hospital	___ Asthma Education / Adherence issues ___ Persistent/Daily ___ Intermittent/Episodic
Chronic Cough		Duration: _____ ____ Persistent/Daily ___ Intermittent/Episodic	
Recurrent Infection		___ Frequent Respiratory Infections ___ Recurrent Pneumonia	
Other Respiratory Symptoms		___ Stridor / Noisy Breathing ___ Possible Vocal Cord Dysfunction	___ Exercise intolerance/dyspnea with activity
BPD/Prematurity		___ Bronchopulmonary dysplasia (BPD) ___ Apnea of Prematurity ___ Oxygen Therapy	
Cystic Fibrosis		___ Cystic Fibrosis (Transfer Patient) ____ Cystic Fibrosis -abnormal newborn screen/sweat test	
Sleep Disordered Breathing		___ Snoring /sleep disordered breathing ___ Obstructive Sleep Apnea or OSA Risk	___CPAP/BiPAP Management ___ Abnormal Sleep Study
Airway Obstruction or Aspiration		___ Swallowing/choking risk ___ Chronic Chest Congestion	
Pulmonary Hypertension ***(main campus ONLY)***		___ New diagnosis ___ Established on therapy	Functional Class: I = no symptoms at rest, IV = symptoms at rest I II III IV
Other		___ Chronic Lung Disease ___ Pectus excavatum/chest deformity ___ Restrictive lung disease ___ Interstitial lung disease ___ Down Syndrome related	___ Abnormal Chest x-ray or CT chest ___ Adolescent Smoking/Tobacco Dependence ___ Ventilator management ___ Oxygen Therapy ___ Other _____

If your patient needs to be seen in one week or less,
please call 832-822-3327 to speak with a Pulmonary Physician.