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)
- ____ Sugar Land Health Ctr (15400 SW Frwy)
- ____ The Woodlands Health Ctr (17198 St. Luke's Way)
- ____ 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 #

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 lab/diagnostic reports.*
For TCPA, will refer to EPIC.

Diagnosis/Problem

Asthma	___ Confirmation of diagnosis ___ Asthma Education / Adherence issues ___ Inadequate control Life Threatening Asthma: ___ Past ICU ___ Past Intubation ___ # of Visits ED/Hospital
Recurrent Wheezing	___ Persistent/Daily ___ Intermittent/Episodic
Chronic Cough	Duration: _____________ ____ Persistent/Daily ___ Intermittent/Episodic
Recurrent Infection	___ Frequent Respiratory Infections ___ Recurrent Pneumonia
Other Respiratory Symptoms	___ Stridor / Noisy Breathing ___ Question of Vocal Cord Dysfunction ___ Exercise intolerance/difficulty breathing 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 / Breathing difficulty during sleep ___ Obstructive Sleep Apnea or OSA Risk ___CPAP/BiPAP Management ___ Abnormal Sleep Study
Airway Obstruction or Aspiration	___ Swallowing/choking risk ___ Chronic Chest Congestion
Other	___ Chronic Lung Disease ___ Pectus excavatum or thoracic deformity ___ Restrictive lung problem ___ Interstitial Lung Disease ___ Pulmonary hypertension ___ Abnormal Chest x-ray ___ Abnormal CT chest ___ Ventilator management ___ Oxygen Therapy ___ Other _______________

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