Referral to Aerodigestive

Texas Children's Hospital®

* = Required Field

*Patient First Name | *Patient Last Name | *Patient DOB | *Patient Gender

☐ M ☐ F

month/day/year - ex 01/02/2018

*Parent/Guardian First Name | *Parent/Guardian Last Name | *Parent/Guardian Mobile Number | *Parent/Guardian Alternate Number

Enter a 10-digit Phone Number | Enter a 10-digit Phone Number

*Please provide information for the licensed referring provider. Medical students, list your authorizing physician as the referring provider.

*Referring Provider NPI# | *Referring Provider First Name | *Referring Provider Last Name | *Referring Provider Office Phone Number

Enter a 10-digit Phone Number

*Referring Provider Fax Number | Referring Provider Office Address | City | State | Zip Code

choose

***Reason For Consultation** *(Check all that apply to the patient):*

*Airway/ENT

☐ Congential Anomalies (e.g. TEF) ☐ Laryngomalacia/Tracheomalacia/Noisy Breathing

☐ Status-Post Tracheostomy ☐ Voice/Vocal Cord Disorder ☐ Laryngeal Cleft ☐ Other

*Pulmonary

☐ Severe or Difficult to Control Asthma ☐ Chronic Lung Disease/Bronchopulmonary Dysplasia

☐ Recurrent Pneumonia ☐ Chronic Cough ☐ Chronic Oxygen and/or Ventilator Dependence

☐ Other

*Gastrointestinal

☐ Gastroesophageal Reflux ☐ Feeding Intolerance/Vomiting/Delayed Gastric Emptying

☐ Swallowing Dysfunction/Aspiration ☐ Poor Growth/Failure to Thrive

☐ Status-Post G-Tube, GJ-Tube, Fundoplication ☐ Other

Other Pertinent Diagnosis or Surgical History:

***Visit needed ASAP** (Clinically needs to be seen within 1 week):

☐ Yes ☐ No

ASAP – Please provide additional detail(s) regarding urgency

Preferred Location (if known):

☐ Medical Center

Fax insurance authorization to 832-825-3072.

Fax all applicable records, labs, and/or imaging with this referral to 832-824-7333 so that we can better assess the patient's healthcare needs.