Referral to Brachial Plexus

Texas Children's Hospital®

* = Required Field

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

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 Referral:** ☐ Brachial Plexus ☐ Arm Weakness

* Side Affected: ☐ Left ☐ Right ☐ Bilateral

* Cause of injury: ☐ Neonatal ☐ Traumatic

*If traumatic, is it recent? ☐ Yes ☐ No

* Does patient have:

* Movement of the Shoulder: ☐ Yes ☐ No

* Ability to bend/flex Elbow: ☐ Yes ☐ No

*Movment of the Wrist/Fingers: ☐ Yes ☐ No

* Is there drooping of the eye or eye asmmetry on the affected side? ☐ Yes ☐ No

* Has there been any concerns with a diaphragm injury or other breathing problems? ☐ Yes ☐ No

* Has there been prior imaging (X-ray, Ultrasound or MRI)? ☐ Yes ☐ No

* Has there been prior nerve conduction study or EMG? ☐ Yes ☐ No

* Has the patient started therapy or had therapy in the past? ☐ Yes ☐ No

* Has the patient had prior surgery? ☐ Yes ☐ No

* If yes, when was the surgery?

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

◯ Yes ◯ No

ASAP – Please provide additional detail(s) regarding urgency

Preferred Location:

◯ West Campus

Fax insurance authorization to 832-825-3072.
Fax this referral to 832-824-7333 and have the patient bring any birth history records, imaging reports, EMG reports, operative reports, and/or hospitalization records to their appointment.