Nicklaus Children's Hospital

MIAMI CHILDREN'S HEALTH SYSTEM

Phone: 305-663-8413
Fax: 305-662-8305

❑ New Appointment ❑ Reschedule

Hospital Use Only:

Location:_____

Appointment Date: _____

Appointment Time: _____

Arrival Time:_____

Scheduled by:_____

Special Instructions: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Confirmation Number:

Central Scheduling Appointment Form

Procedure:		
Specifications:	Sedation: ❑ Yes ❑ No	
	Additional:	
Diagnosis:		
Patient:	Name:	
	Date of Birth:	Gender: ❑ M ❑ F
Referring Physician:	Name:	
	Phone:	
	Fax:	
Primary Care Physician:	Name:	
	Phone:	
Patient's Address:	Street:	
	City:	
	State:	Zip Code:
Phone Numbers:	Primary:	
	Secondary:	
Mother:	Name:	
	Date of Birth:	
Father:	Name:	
	Date of Birth:	
Insurance:	Company:	
	Phone Number:	
	Policy Number:	
	Group Number:	
Subscriber:	Name:	
	Date of Birth:	
Preferred Appointment:	Date:	
	Time:	
Form Completed by		

Medical History

Is the patient any of the following:

❑ Over 18 years old and cannot physically sign for themselves?

❑ Ward of the state?

❑ Have a non-parental guardian?

❑ None

ALLERGIES: ❑ Iodine ❑ Seafood ❑ None

Does the patient have any metals in the body: (For example: ear tubes, clips, shunts [programmable or non-programmable], ITB pump, PDA[metal in heart], pacemaker, Vagus Nerve Stimulator, braces/dental work)

❑ Yes ❑ No

If yes, please specify:_____

Has the patient had any heart, brain or orthopedic surgeries?

❑ Yes ❑ No

If yes, please specify:_____

How much does the patient weigh? _____ lbs

Only for patients that are one year of age or younger: Is the patient a preemie?

❑ Yes ❑ No ❑ N/A

Mark all of the following that apply:

HISTORY:

❑ Sleep Apnea

❑ Congenital Disorders (for ex: Down Syndrome or any syndrome)

❑ Tremors

❑ Tics

❑ Seizure/Epilepsy

❑ Cortical Dysplasia

❑ Abnormal movements

❑ Abnormal EEG

❑ Previous problem with sedation including fiber optic intubations

❑ Possible Proximal Events

❑ Tuberous Sclerosis

❑ None

Has the patient had any previous related studies/exams (for ex: x-rays, ultrasounds, MRI, CT, etc.)?

❑ Yes ❑ No

If yes, please specify:_____