Nicklaus Children's Hospital

MIAMI CHILDREN'S HEALTH SYSTEM

Phone: 305-663-8413
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❑ New Appointment ❑ Reschedule

Hospital Use Only:

Location:________________________________

Appointment Date: ________________________

Appointment Time: ________________________

Arrival Time:_____________________________

Scheduled by:____________________________

Special Instructions: ______________________

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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:_______________________________