Nicklaus Children's Hospital

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

MCH Use Only:

Location:_____

Appointment Date: _____

Appointment Time: _____

Arrival Time:_____

Scheduled by:_____

Special Instructions: _____

_____

_____

_____

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_____

Confirmation Number:

Outpatient Diagnostic 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:_____

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:

❑ Abnormal movements
❑ Congenital Disorders (for ex: Down Syndrome or any syndrome)
❑ Previous problem with sedation including fiber optic intubations
❑ Heart Conditions
❑ Sleep Apnea
❑ None

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

❑ Yes ❑ No

If yes, please specify:_____