UniCare Health Plan of West Virginia, Inc.
Medicaid Managed Care

PCP Checklist for Tonsillectomy in Children

Patient Name: _____	**Patient DOB:** _____
Member ID #: _____	**PCP Name:** _____
Accompanying Referral #: _____	**Referral Date:** _____

PCP to complete & send to ENT specialist:

1. Has the patient had a pattern of recurrent of throat infections? (check as applicable)

- ☐ **7 episodes in the past year**
- ☐ **5 episodes per year for 2 years**
- ☐ **3 episodes per year for 3 years**

Has at least one of the following been associated with every episode?

Temperature > 38.3°C (100.94°F
Cervical adenopathy
Tonsillar exudates or erythema
Positive test for Group A ß-hemolytic streptococcus (GABHS)

☐ **Yes** ☐ **No**

OR

2. Does the patient have history of recurrent throat infections with any of these factors? (check all that apply)

- ☐ **Multiple antibiotic allergies/intolerances**
- ☐ **PFAPA (periodic fever, aphthous stomatitis, pharyngitis, and adenitis) syndrome**
- ☐ **Peritonsillar abscess**
- ☐ **Peritonsillar abscess**

OR

3. Does the patient have the following?

Tonsillar hypertrophy, a diagnosis of sleep-disordered breathing, and a condition related to the sleep-disordered breathing (e.g., growth retardation, poor school performance, enuresis, and behavioral problems) that is likely to improve after tonsillectomy.

☐ **Yes** ☐ **No**

OR

4. Is there a suspicion of tonsillar malignancy?

☐ **Yes** ☐ **No**

PCP signature: _____

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