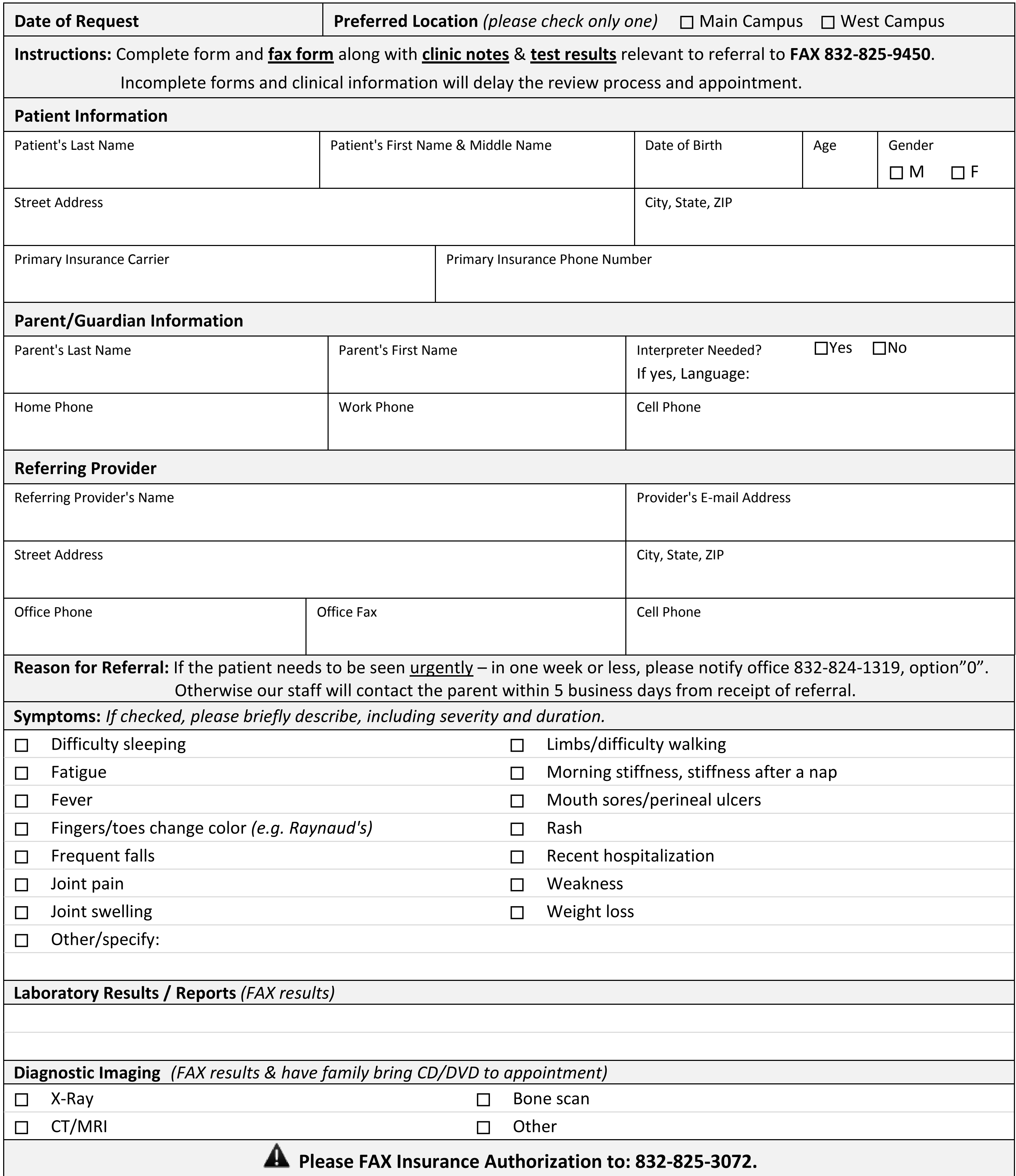
Texas Children's Hospital

Rheumatology New Appointment Request & Clinical Triage Form

Phone: (832) 824-1319 **Fax: (832) 825-9450**



Date of Request	**Preferred Location** *(please check only one)* ☐ Main Campus ☐ West Campus

Instructions: Complete form and **fax form** along with **clinic notes** & **test results** relevant to referral to **FAX 832-825-9450**.
Incomplete forms and clinical information will delay the review process and appointment.

Patient Information

Patient's Last Name	Patient's First Name & Middle Name	Date of Birth	Age	Gender ☐ M ☐ F

Street Address	City, State, ZIP

Primary Insurance Carrier	Primary Insurance Phone Number

Parent/Guardian Information

Parent's Last Name	Parent's First Name	Interpreter Needed? ☐Yes ☐No If yes, Language:
Home Phone	Work Phone	Cell Phone

Referring Provider

Referring Provider's Name	Provider's E-mail Address
Street Address	City, State, ZIP

Office Phone	Office Fax	Cell Phone

Reason for Referral: If the patient needs to be seen urgently – in one week or less, please notify office 832-824-1319, option"0".
Otherwise our staff will contact the parent within 5 business days from receipt of referral.

Symptoms: *If checked, please briefly describe, including severity and duration.*

☐ Difficulty sleeping	☐ Limbs/difficulty walking
☐ Fatigue	☐ Morning stiffness, stiffness after a nap
☐ Fever	☐ Mouth sores/perineal ulcers
☐ Fingers/toes change color *(e.g. Raynaud's)*	☐ Rash
☐ Frequent falls	☐ Recent hospitalization
☐ Joint pain	☐ Weakness
☐ Joint swelling	☐ Weight loss
☐ Other/specify:	

Laboratory Results / Reports *(FAX results)*

Diagnostic Imaging *(FAX results & have family bring CD/DVD to appointment)*

☐ X-Ray	☐ Bone scan
☐ CT/MRI	☐ Other

⚠ Please FAX Insurance Authorization to: 832-825-3072.