Ann & Robert H. Lurie Children's Hospital of Chicago

# Otolaryngology Head and Neck Surgery Request for Service Order

**Pt. Name:**_____

**DOB:**_____

MRN (If available):_____

Parent Name_____

**Phone #**_____Preferred time: ☐ 8-12, ☐ 12-5, ☐ after 5

Insurance: ☐ Medicaid, ☐ PPO, ☐ HMO, ☐ Self-pay / Other

Referring Provider Name: _____

Practice Name:_____

Date of Request:_____

**Please attach patient's demographics**

## Step 1: When should patient be seen?

☐ ASAP (≤ 24 hours)

- For physicians new to Lurie Children's – Call the VIP Physician Hotline **– 800.540.4131, Option 4**
- For all other physicians, call the Lurie Children's ORL-HNS Department Directly at 312.227.6230

☐Within 2 weeks

☐ > 2 weeks

## Step 2: Identify Chief Complaint

☐ Oral Cavity/Oropharyngeal Issues
- ☐ Sleep Disorder Breathing
  - ☐ Tonsil size (Circle) 1+ 2+ 3+ 4+
  - ☐ Apnea > 5sec
  - ☐ Mouth Breather
  - ☐ Snoring
  - ☐ Enuresis
  - ☐ Restless
  - ☐ Behavioral / School Performance
- ☐ Tongue Tie
- ☐ Oral Cavity Mass

☐ Recurrent Tonsillitis
____# of Infections in 6 Months
____# of Infections in 12 Months

☐ Otologic Issues
- ☐Otitis Media
  ____# of Infections in 6 Months
  ____# of Infections in 12 Months
- ☐ Middle Ear Effusion
  ____present ___ months
- ☐ Foreign Body
- ☐ Ear Deformity
- ☐ Hearing Loss

☐ Aerodigestive Issues
- ☐ Stridor
- ☐ Recurrent croup
- ☐ Feeding Concerns
- ☐ Reflux
- ☐ Hoarseness

☐ Nasal/Sinus Issues
- ☐ Recurrent Sinusitis
- ☐ Nasal Obstruction
- ☐ Rhinitis
- ☐ Epistaxis
- ☐ Nasal Trauma

☐ Head and Neck Masses
- ☐ Neck Mass
- ☐ Enlarged Lymph Node
- ☐ Cyst
- ☐ Parotid Mass
- ☐ Thyroid Mass
- ☐ Pre auricular Sinus/Skin Tag

☐ Other: _____
_____

## Step 3: Info Requested for Each Referral

1) **How long has the patient had the condition?**_____(days/weeks/months)

2) **Pertinent and Quick Patient History (1 – 2 sentences):** (Please Print)

_____

_____

3) **Questions referring provider wants answered by Specialist**

_____

_____

4) **Has the referring provider already spoken with a Lurie specialist about this referral?**

_____

5) **Is there a preferred provider to see the patient?**

_____

6) **Which location is preferred for the patient's appointment?**

_____

**Ensure the following are submitted along with this Request for Service Order**

1. Current Medications (Nasal Steroids, Reflux medications, other medication if pertinent to referral)
2. Pertinent Labs
3. Imaging
4. Audiogram
5. Sleep Study (if available)
6. Previous Otolaryngology Consults (if available)

**Please submit this request along with records to KidsDoc Fax #: 312.227.9832**