Attention

Please….Do **not** wear any of the following:

- Perfumes
- Colognes
- Aftershave
- Scented Lotions
- Scented Hair Sprays

These can irritate and increase respiratory symptoms in some of our patients.

Thank you for your cooperation!

Pediatric Clinic Patients

General Information

The Pediatric Clinic at National Jewish is designed to provide patients and their families a multi-disciplinary approach to managing your child's illness. Our physicians are specially trained in Pediatric Asthma and Allergy, as well as Immunology, Psychiatry, Rheumatology, and Pulmonology.

Day of Admission

We ask that families arrive 30-minutes before their scheduled appointment, and report to the Check-In desk on the second floor of the May Building. If your child needs medical attention before their appointment, you may be seen in the Pediatric Triage area, where your child can receive immediate care. Please call (303) 398-4461, if you are concerned. If your child is having significant breathing problems or other emergent conditions, call 911.

In this packet, you will find a **Pediatric Initial Evaluation Form**. We ask that you complete this and hand carry it with you. It is important that you have this questionnaire completed by the time of the appointment.

Should your arrival time be delayed, please call (303) 398-1515, as it may be necessary to reschedule your appointment.

Length of Stay

Anticipated length of treatment varies from patient to patient, and depends upon whether your child is considered a local or non-local patient.

Local Patients

For local patients, we will schedule a 1-hour first-time evaluation appointment with the physician. For patients scheduled into the Asthma Allergy Clinic, allergy skin testing, which lasts 45-minutes, will also be scheduled, when necessary. Allergy skin testing will be done at the physician's discretion and after discussion with the parents. A follow-up appointment is advised to discuss treatment and test results.

Non-Local Patients

For non-local patients, we will schedule a seven (7) day visit. Generally, this will require you to stay over the weekend. We will schedule three (3) appointments with the same physician spaced out over the seven (7) days. The first appointment will last 90-minutes, the following two (2) lasting 30-minutes each. We schedule in this manner, so that you and your child are locally available should the physician need to order any tests or procedures during your child's stay.

Non-Local Immunology Patients

For patients scheduled with Dr. Gelfand, we will schedule a 90-minute appointment. We would ask you to be available through the Friday following your appointment to complete any necessary testing.

Family Members and Visitors

We understand that some families have no alternative but to bring siblings, however, we strongly recommend that families arrange for adult supervision. If no alternative arrangements can be made, parents must understand that there is no child care available, and that all children must be supervised at all times.

Where to Stay

Please refer to the **Lodging List** sheet included in this packet. It includes a list of local area hotels that offer special discounts and rates to National Jewish patients.

Getting to National Jewish

Please refer to the **Travel Information** sheet in your admission packet.

Cafeteria

The cafeteria is located on the first floor in the Perlmutter Dining Center. Patients, visitors, and employees are all welcome to dine there. (Please note, the cafeteria does not serve dinner.)

The cafeteria hours are:

Meal	*Hours (Monday - Friday)*
Breakfast	7:00 am to 9:30 a.m.
Mid-Morning Snack	9:30 am to 10:30 a.m.
Lunch	11:30 am to 1:30 p.m.
Afternoon Snack	1:30 pm to 4:00 p.m.

Coin-operated vending machines are located throughout the hospital. A microwave oven is available in the cafeteria, and on the unit, and may be used free of charge.

Medications

Certain medications may need to be held prior to your child's arrival at National Jewish. Please refer to the **Preparing for Your Tests** handout included in your packet for specific medications. Please contact the Pediatric Clinic nursing staff at (303) 398-1691 with questions.

Patient's Access to Medical Records

A patient's medical record is documentary evidence of the course of his or her medical evaluation, treatment and health care services rendered under the direction of a qualified physician.

In accordance with Public Law 1018, National Jewish will honor all requests for inspection and/or photocopies of the medical record from current inpatients, discharged patients, outpatients, and emergency patients.

The patient medical summary is available without charge. Copies of additional medical record are also available. Please contact the Medical Records Correspondence Department at (303) 398-1256 for charges and directions. If a parent wishes to inspect and/or receive copies of their child's record, requests must be made in writing, signed and dated, and should be made through the Medical Records Department.

Whether your child comes to National Jewish as an inpatient or outpatient, we are pledged to protect your rights in our concern for your child's well being. We will deliver your child's medical care thoughtfully, considerately, and at all times strive for excellent quality of care.

Patient Billing

You may examine and receive an explanation of your bill prior to discharge. You may inquire about the availability of financial aid to assist in the payment of your hospital bill prior to receiving services. You can expect prompt and accurate information and assistance from hospital staff. Please contact our Patient Financial Office at (303) 398-1065 with any questions/concerns.

Pharmacy

National Jewish has an onsite pharmacy to provide prescription services for medications that your physician may prescribe during your stay. The pharmacy can process most prescription insurance claims electronically when the prescription is filled. However, payment by cash, check or major credit card is required when prescriptions are picked up at the pharmacy. We think that you will find our pharmacy services convenient and competitively priced. The pharmacy staff will be glad to answer any questions you may have regarding your medications or prescription charges by calling (303) 398-1582 or visiting the pharmacy located in the main lobby.

The pharmacy hours are:

Monday - Friday, 8:30 a.m. to 6:00 p.m.;

Parking

Valet parking is available to our patients and visitors free of charge. The Valet parking hours are:

Monday - Friday, 8:00 a.m. to 4:30 p.m.

Library

The Tucker Medical Library on the first floor of the Goodman Building is open to patients and their families. The emphasis of the library collection is scientific and medical, serving the health professional and research community. The library hours are:

Monday - Friday, 8:00 a.m. to 5:00 p.m.

Limited materials are available on a consumer level. Popular fiction in the form of a paperback exchange is available, as well as popular recreational magazines. Patients and families are welcome to come to the library to sit and read in a quiet, pleasant atmosphere.

Photocopies can be made in the library for a fee of 10¢ per copy.

Newspaper stands are located in the lobby of the Goodman Building near the library, and on the second floor of the Goodman building near the elevators.

Security

National Jewish maintains a 24-hour security system. A security guard is on the premises at all times and is readily available, responding to all calls and assisting with any security problems you may have. If you have a problem or question concerning security, please inform your nurse who will contact the security guard. You may speak with the security guard privately.

All hospital building access is controlled by an electronic security system. Closed circuit TV cameras on patient entrance doors are used in the evenings for your security. A security escort is available as needed. Please contact (303) 398-1776 with any questions/concerns. Security guards will also escort patients and families to parking on campus, when requested.

Restricted Areas

Certain areas of the campus are off-limits to visitors. Special isolation areas are well marked.

Patient Representative Program

A Patient Representative is available to assist patients and families with special concerns that are not resolved by members of the patient's care team. Contact the Patient Representative by calling (303) 398-1076, or by dialing the in-house operator.

Your Guidelines as a Patient

You and your child will receive the greatest benefit from our care at National Jewish by meeting the following responsibilities:

- **DO NOT wear perfumes, colognes, aftershave, scented lotions, or scented hairspray.**
- National Jewish is a **NON-SMOKING** facility.
- Be honest and direct about aspects of your life that relate to your child's illness and experience here. Those who are caring for your child need to know your opinions and concerns so they can provide you and your child with the best care possible.
- Participate in patient education sessions and ask questions to learn about your child' s medical condition and their treatment plan.
- Report any changes in your child's health to your doctor or nurse.
- Keep your scheduled appointments. Please notify the Pediatric Patient Administrative Services Department at (303) 398-1331 well in advance if you cannot keep an appointment.
- Know the medicines your child is taking.
- Support National Jewish's commitment to the education of future health professionals, including the specialized training of physicians. As in any teaching institution, patients receiving medical care in this hospital are an important part of this ongoing educational process.
- Your child may require testing at another healthcare facility. The staff will assist you in making these arrangements.
- Keep track of your personal belongings and valuables.
- Be considerate of other patient's privacy. Please limit your visitors, and request visitors to maintain a quiet atmosphere. Telephones and televisions are available in the patient rooms and lobby; no personal televisions are allowed

How to Request Medical Records

If you want your medical records mailed to National Jewish Health, please comply with the following:

1. Complete the attached form.

2. Mail or hand deliver the attached form to your physician and/or hospital where services have been provided to you.

Please DO NOT mail the completed form to National Jewish Health.

National Jewish Health

Authorization to Release Protected Health Information

Patient Information

Full Name _____ Medical Record # _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Date of Birth _____

I hereby authorize:

- ☐ National Jewish Health - Main Campus 1400 Jackson St Denver, CO 80206 PH (303) 398-1580 FAX (303) 398-1211
- ☐ NJH - Highlands Ranch 8671 S. Quebec St. Ste 120 Highlands Ranch, CO 80130 PH (303) 703-3646 FAX (303) 738-1385
- ☐ NJH - South Denver 499 E. Hampden Ave. Ste 300 Englewood, CO 80113 PH (303) 788-8500 FAX (303) 788-8505
- ☐ Other:

Name/Title Organization _____

Address _____

City/State/Zip _____ Phone _____ Fax _____

Release To

Release to:

- ☐ National Jewish Health - Main Campus 1400 Jackson St Denver, CO 80206 PH (303) 398-1580 FAX (303) 398-1211
- ☐ NJH - Highlands Ranch 8671 S. Quebec St. Ste 120 Highlands Ranch, CO 80130 PH (303) 703-3646 FAX (303) 738-1385
- ☐ NJH - South Denver 499 E. Hampden Ave. Ste 300 Englewood, CO 80113 PH (303) 788-8500 FAX (303) 788-8505
- ☐ Other:

Name/Title Organization _____

Address _____

City/State/Zip _____ Phone _____ Fax _____

- ☐ Other:

Name/Title Organization _____

Address _____

City/State/Zip _____ Phone _____ Fax _____

Purpose & PHI Disclosed

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other _____

For Treatment Date(s) _____

☐ Clinic Summary/Consultation ☐ Procedure ☐ Laboratory/Radiology ☐ Pulmonary Test ☐ Cardiology Test

☐ Other _____

Fees

Pages	1-10	11-40	41+
Patient	$14.00	.50 each	.33 each
Others	$16.50	.75 each	.50 each

According to Colorado State Statute, 6 C.C.R. 1011-1, Chapter 2 Part 5.2.3.4 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge.

Authorization

_____By **initialing** this area, I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which my include, but are not limited to: hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS or Human Immune Deficiency Virus (HIV).

_____By **initialing** this area, I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

This request is made voluntarily and the information given is accurate to the best of my knowledge.

I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.

I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA privacy rule.

Without my express revocation, this consent will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.

Signature

My signature is required to validate this Authorization. If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Patient or Authorized Representative Signature _____ Date _____ Relationship _____

Referring Physician Information

In order to provide results and recommendations from your child's evaluation at National Jewish, to your child's physician at home, we need to have complete information. Please complete this form and return it to the Pediatric Services Administration Department when you arrive for your child's appointment.

Primary Care Physician (Last, First):_____

Address:_____
(Street) (Suite #)

_____
(City) (State) (Zip)

Telephone:_____ Fax:_____

Specialist Physician (Last, First):_____

Address:_____
(Street) (Suite #)

_____
(City) (State) (Zip)

Telephone:_____ Fax:_____

Specialist Physician (Last, First):_____

Address:_____
(Street) (Suite #)

_____
(City) (State) (Zip)

Telephone:_____ Fax:_____

Specialist Physician (Last, First):_____

Address:_____
(Street) (Suite #)

_____
(City) (State) (Zip)

Telephone:_____ Fax:_____

I authorize National Jewish Health to release medical information to the above physicians.

Patient/Parent
Signature:_____

National Jewish Health

Science Transforming Life™

Preparing for Your Tests

Your doctor has recommended your child have certain tests as part of your evaluation at National Jewish Health. The most frequently ordered test is Allergy Testing. This test can include up to 40-skin pricks per appointment. The testing is usually done on the back and is relatively painless. Try to avoid lotions, oils, and creams on the back for this test. **All oral antihistamines will need to be stopped prior to testing as they can affect the results**. Check with your child's doctor before you stop any medicines.

- Withhold oral antihistamines for the designated length of time before your appointment.

  ► Withhold these oral antihistamines for **5-days** prior to your appointment:

  Claritin® (Loratadine), Allegra® (Fexofenadine), Clarinex® (Desloratadine)

  ► Withhold these oral antihistamines for **3 - 4 days** prior to your appointment:

Actifed®, Dimetapp®	(Brompheniramine)
Atarax®, Vistaril®	(Hydroxyzine)
Benadryl®	(Diphenhydramine)
Chlortrimeton®	(Chlorpheniramine)
Phenergan®	(Promethazine)
Tavist®, Antihist®	(Clemastine)
Actifed®, Aller-Chlor®, Bromfed®, Drixoral®, Dura-tab®, Novafed-A®, Onrade®, Poly-Histine-D®, Trinalin®	(Combination medicines)
Zyrtec®	(Cetirizinei)

  ► Withhold Singulair® (Montelukast) the **night before** your test.

  ► If your child is taking an oral antihistamine that is not listed, hold the medicine for **3 - 4 days** before the appointment. If you are not sure if the medicine your child is taking is an antihistamine, ask your child's doctor, or call the Pediatric phone nurse at (303) 398-1355.

- Continue to take all other medicine as your child usually does.

Patient Financial Responsibility

National Jewish Health is committed to providing quality healthcare and service to all patients. We understand that billing and payment for health care services can be confusing and complicated. Knowing your insurance policy is vital to receiving the maximum benefits possible. Failure to meet your insurance requirements may result in partial or complete claim denial and/or a higher co-payment/or deductible. We request that you pay any insurance co-payments, deductible, and/or co-insurance at the time of registration.

Please be aware, National Jewish Health is a hospital facility and the physicians are employees of the hospital. Therefore, in addition to a specialty physician co-payment, a hospital co-payment, deductible, and/or co-insurance may apply. If you have any questions about your financial responsibility, please contact your insurance carrier.

As a courtesy to patients and their families, National Jewish Health submits claims to most insurance carriers. To insure proper and prompt processing of your claim, it is important that all current insurance information be presented at the time of pre-registration and/or admission. Please have a copy of your insurance card and your driver's license or other form of identification with you when you check-in.

National Jewish Health is a specialty hospital. Consequently, many insurance plans require a referral in order to access health care at National Jewish Health. If your insurance plan has such a requirement, it is your responsibility to obtain a referral from your Primary Care Physician and/or Specialist Physician. Referrals can be faxed to (303) 270-2161.

If your insurance plan requires the medical services scheduled to be pre-certified or pre-authorized, National Jewish Health will attempt to obtain such approval from the insurance plan or the entity responsible for utilization management. Failure to meet your insurance requirements may result in partial or complete claim denial or a higher co-payment/or deductible, and you may be responsible for the remaining balance.

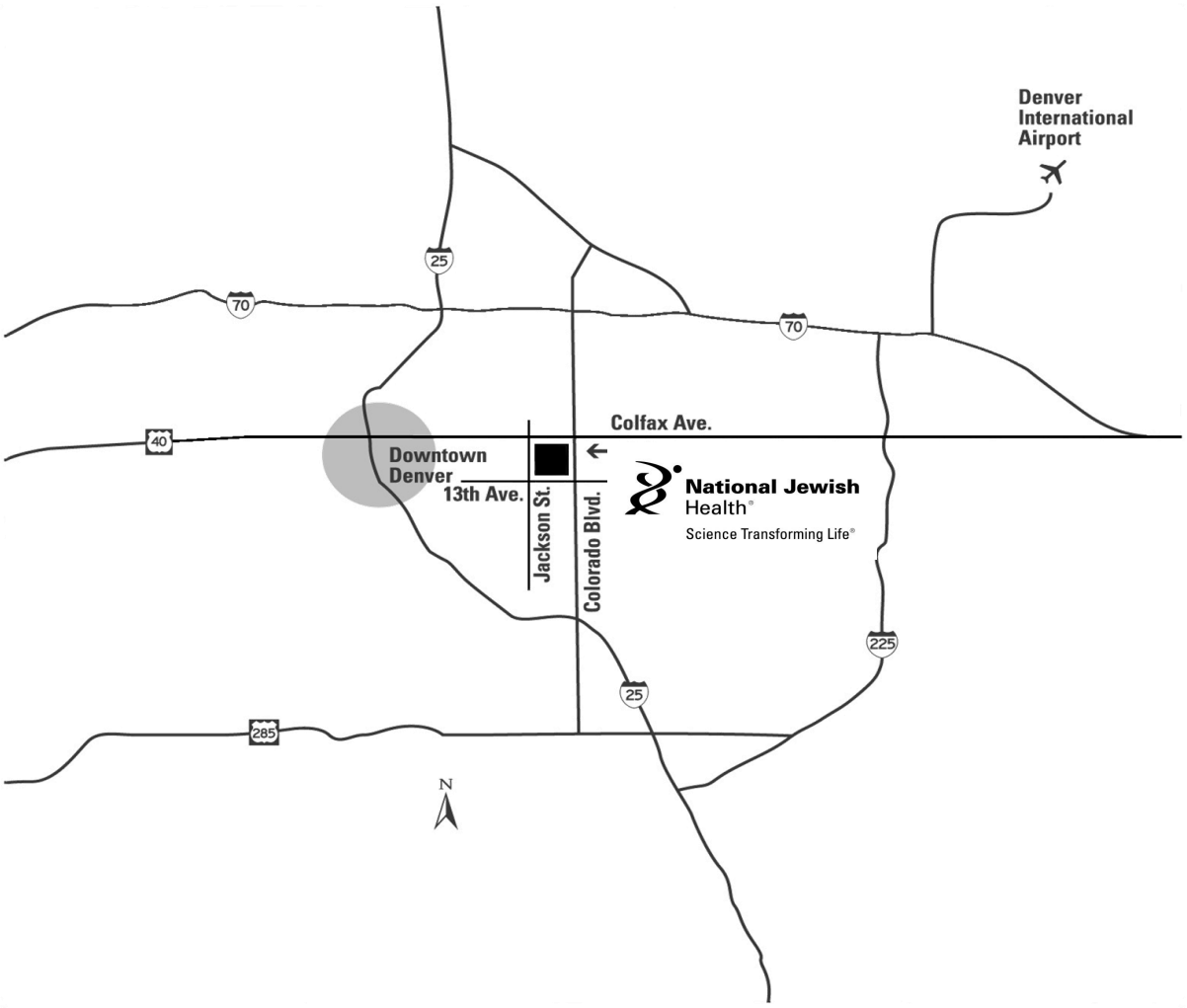
National Jewish Health staff are available to assist you in understanding your hospital insurance benefits. We attempt to verify your insurance benefits prior to medical services being completed. Estimates of your financial responsibility are based on the accuracy of this information. The insurance benefit information provided by your insurance plan is based on the latest information they have available. Please remember that your insurance plan benefits are a contract between you, your employer and your insurance company. It is in your best interest to know and understand your benefits.

In the event you do not have insurance coverage, or cannot pay the patient responsibility portion of your bill, you will be asked to speak with one of our financial counselors. Our financial counselors are trained to assist you in meeting your financial obligations. We offer a variety of payment plans and prompt payment discounts. We accept all major credit cards. Financial counselors can also assist you in applying for charitable or public assistance programs for which you may be eligible. This service is provided to you at no cost. However, your cooperation is essential to successfully qualify for these programs. You are still financially responsible for the medical services until you are qualified for one of the programs. Please contact our Patient Financial Counseling Office at (303) 398-1065 with any questions prior to your visit.

Please remember that all of your co-payments for prescriptions will be collected at the Pharmacy.

National Jewish Health®
Science Transforming Life®

Location Map



To National Jewish from D.I.A.

Follow signs to Airport Exit. Merge on to Pena Blvd. And follow signs to I-70 West.
Merge on to I-70 West. Travel west on I-70 until Colorado Blvd., exit #276B.
Exit on to Colorado Blvd. and turn left (south). Go south on Colorado Blvd. (approximately 3.2 miles to Colfax Avenue.)
Turn right (west) on Colfax Avenue.
Take your first left (south) on to Jackson Street.
Patient parking is ½ block south on the right.

Nan & Dollie's Gift Shop

nan & dollie's
GIFT SHOP
at National Jewish Medical and Research Center

For your convenience, National Jewish operates a gift shop that features unique gifts, cards, candy, snacks and goodies. It is fully stocked with day-to-day essentials, including over-the-counter items, health products recommended by our own medical staff, stamps, magazines, and books.

All proceeds from Nan and Dollie's Gift Shop are used to purchase clinical and research equipment for National Jewish Health.

Hours:
Monday–Friday
8:30am–4:00pm
Closed on Weekends and Holidays

PH: 303-398-7008

(located in the May Building
next to the Cafeteria)

National Jewish Health™

Patient Label

Please use blue or black ink. Please write patient name on each page.

PEDIATRIC PATIENT QUESTIONNAIRE

Patient Name_____ Today's Date ____/____/_____

Date of Birth ____/____/_____ Age _____ Sex ☐ Male ☐ Female

Race (mark one only) ☐ American Indian ☐ Asian ☐ Black or African American

☐ Caucasian ☐ Hispanic ☐ Jewish Ashkenazi ☐ Jewish Sephardic ☐ Middle Eastern/Arabic

☐ Other (specify) _____ ☐ Mixed (specify) _____

Parents' marital status ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Unknown

☐ Other (specify): _____

Child lives with ☐ Both parents ☐ Father ☐ Mother ☐ Other (specify):_____

PHYSICIAN AND PHARMACY INFORMATION

Primary Referring Physician

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

Referring Physician #2

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

Referring Physician #3

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

PHARMACY INFORMATION

Local Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Email _____

Mail Order Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

Alternate Pharmacy

Name _____

Address _____

_____

_____

Phone _____

Fax _____

PAST MEDICAL HISTORY

Length of pregnancy: ☐ Full-term ☐ Early (# of weeks) ____ ☐ Late (# of weeks) _____

Birth weight ___ lbs. _____ oz Type of delivery ☐ Vaginal, normal ☐ Vaginal, breech
☐ Planned C-section ☐ Emergency C-section

Were there problems with the pregnancy? If yes, specify _____

Were there problems with labor or delivery? If yes, specify _____

Did your child have breathing problems at birth?

☐ No ☐ Yes (specify) _____

Was your child breast fed? ☐ No ☐ Yes (specify # of months) _____

Was your child formula fed? ☐ No ☐ Yes (specify formula type) _____

☐ Cow's milk ☐ Soy milk ☐ Other (specify) _____

Did your child have colic? ☐ No ☐ Yes

What was your child's growth pattern? ☐ Normal ☐ Rapid ☐ Slow

What was your child's development rate (sitting, crawling, walking, talking)? ☐ Normal ☐ Delayed

Has your child had any of the following illnesses?

	Yes	No
Chicken pox	☐	☐
RSV	☐	☐

Has your child been vaccinated? **Yes** ☐ **No** ☐

	Yes	No	Age of Onset	Number of Times
Ear infections	☐	☐	_____	_____
Sinus infections	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Croup	☐	☐	_____	_____

Other illnesses ☐ (specify) _____

Has your child been hospitalized? ☐ No ☐ Yes

If Yes, how many times has your child been hospitalized? _____

M M / D D / Y Y Y Y

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

PAST SURGICAL HISTORY

Has your child had any surgeries? ☐ No ☐ Yes

If Yes, complete the following:

Ear Tube(s): Year _____ Reflux surgery: Year _____ Tonsillectomy: Year _____
Appendectomy: Year _____ Adenoidectomy: Year _____ Hernia Repair: Year _____
Sinus Surgery: Year _____ Other: (specify) _____ Year _____

IMMUNIZATION HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No (explain) _____
_____

Did your child have a flu shot this year? ☐ Yes

ALLERGY HISTORY

Is your child allergic to foods? If Yes, mark all that apply.

☐ Milk ☐ Egg ☐ Soy ☐ Wheat ☐ Peanuts ☐ Tree nuts (i.e. walnuts, pecans, etc.)
☐ Shellfish ☐ Fish ☐ Other (specify) _____
_____
_____

	Yes	No	Unknown
Is your child allergic to animals? ☐ Cats ☐ Dogs ☐ _____	☐	☐	☐
Is your child allergic to medications?	☐	☐	☐
Specify _____			
_____			
Is your child allergic to ☐bee ☐ wasp ☐ yellow jacket ☐ hornet sting?	☐	☐	☐
Is your child allergic to ☐ ant stings? ☐mosquitoes?	☐	☐	☐
Does your child have ☐atopic dermatitis ☐ eczema?	☐	☐	☐
Does your child have frequent hives or swelling?	☐	☐	☐
Does your child have nasal allergies?	☐	☐	☐
If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter			
Does your child have eye symptoms from allergies?	☐	☐	☐
If Yes, when? (mark all that apply) ☐ Spring ☐ Summer ☐ Fall ☐ Winter			

FAMILY MEDICAL HISTORY

Child's Father: Age _____ years Occupation: _____
Does he have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy _____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Mother: Age _____ years Occupation:
_____

Does she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Child's Brothers/Sisters? Number: _____

Sibling 1: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 2: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Sibling 3: Age _____ years ☐ Female ☐ Male

Does he/she have any of the following conditions? (mark all that apply)

☐ No allergies ☐ Allergy to animals _____ ☐ Asthma
☐ Food allergy_____ ☐ Hay fever ☐ Insect sting allergy
☐ Latex allergy ☐ Medication allergy_____ ☐ Eczema

Does any family member have cystic fibrosis? ☐ Yes ☐ No

Does any family member have any other type of lung disease? ☐ Yes ☐ No

Specify _____

HOME ENVIRONMENTAL HISTORY

What type of dwelling does the child live in? ☐ Apartment ☐ Condo ☐ House ☐ Townhouse ☐ Mobile home ☐ Other (specify): _____

What year was the current residence built? _____ Or age in years _____ years

How long has the child lived in the current residence? _____ Years _____ Months

Is there a basement? ☐ No ☐ Yes (mark all that apply):

☐ Finished ☐ Unfinished ☐ Dry ☐ Damp ☐ Flood damage

What type of heating system does the residence have? (mark all that apply)

☐ Electric baseboard heat ☐ Fireplace ☐ Forced hot air (gas)
☐ Hot water radiator or furnace ☐ Space heater ☐ Wood burning stove

☐ Other (specify): _____

What type of cooling system does the residence have? (mark all that apply)

☐ Central air conditioning ☐ Swamp cooler ☐ Window (room) air conditioning ☐ None

What type of air filtration unit does the residence have? (mark all that apply)

☐ Central air filter ☐ Portable air filter ☐ None ☐ Unknown

What type of humidifier is in the residence? (mark all that apply)

☐ Humidifier on central system ☐ Portable humidifier ☐ None ☐ Unknown

What type of window coverings are there in the residence? (mark all that apply)

☐ Curtains ☐ Venetian blinds ☐ Other (specify) _____

What type of furnishings does your child's bedroom have? (mark all that apply)

Flooring: ☐ Carpet ☐ Hardwood ☐ Tile ☐ Other (specify): _____

Pillow(s): ☐ Feather ☐ Foam ☐ Polyfill ☐ Other (specify): _____

How old are the pillows? _____ years

Mattress: ☐ Regular ☐ Waterbed ☐ Other (specify): _____

How old is the mattress? _____ years/months

How many stuffed animals are in the bedroom? _____

How many smokers live in the residence? _____

☐ Child (patient) ☐ Father ☐ Mother ☐ Sibling(s)

☐ Other relatives ☐ Other visitors

Do you have pets/animals? (mark all that apply)

☐ Bird(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Cat(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Dog(s): number: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

☐ Other (specify):

_____: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

_____: ____ ☐ Indoor☐ Outdoor☐ Indoor/Outdoor☐ In bedroom

SOCIAL HISTORY

1. What grade is your child in? _____ ☐ Not applicable
2. Is your child home-schooled? ☐ YES ☐ NO
3. Does your child attend daycare? ☐ YES ☐ NO
   How many hours per week? _____ hours
   How many children are in his/her daycare? _____
4. Does your child have problems in school with learning or with teachers? ☐ Yes ☐ No
5. Is your child in special education classes? ☐ Yes ☐ No
   (If YES, please bring an individualized education plan: IEP)
6. Has your child had psychological testing? ☐ Yes ☐ No
   (If YES, please bring a copy of the report)
7. What are your child's hobbies/interests? _____
8. Does your child have any of the following difficulties or problems?
   a. Making or keeping friends ☐ YES ☐ NO
   b. Paying attention ☐ YES ☐ NO
   c. Overly active ☐ YES ☐ NO
   d. Frequent worrying ☐ YES ☐ NO
   e. Frequent stress ☐ YES ☐ NO
   f. Frequent sadness ☐ YES ☐ NO
   g. Frequent anger or irritability ☐ YES ☐ NO
   h. Taking medications ☐ YES ☐ NO
   i. Fear of medical procedures ☐ YES ☐ NO
9. Has your child ever received any counseling or therapy for any of these problems? ☐ YES ☐ NO
   (If YES, which one(s)? _____

10. Has your child ever received any medication for any of these problems? ☐ YES ☐ NO
    (If YES, which one(s)? _____
11. Has your child's illness caused excessive stress or disruptions for the family? ☐ YES ☐ NO
12. Do you think your child has a problem sleeping? ☐ YES ☐ NO
    (If YES, is this related to your child's health (e.g., itching, wheezing, pain)? ☐ YES ☐ NO

HEALTH PROBLEMS (REVIEW OF SYSTEMS)

General Symptoms ☐ Fatigue ☐ Fever/chills ☐ Trouble sleeping ☐ Loss of appetite
☐ Other (specify): _____

Eyes ☐ Blurred vision ☐ Burning ☐ Cataracts ☐ Frequent blinking
☐ Far-sighted ☐ Itching ☐ Lazy eye ☐ Near-sighted
☐ Redness ☐ Swelling ☐ Watery eyes ☐ Wears glasses
☐ Other (specify): _____
Date of last eye examination _____month / year

ENT ☐ Change in sense of smell ☐ Dry mouth ☐ Ear pain
☐ Enlarged lymph nodes ☐ Hearing loss ☐ Hoarseness/change in voice
☐ Itchy eyes ☐ Itchy nose ☐ Mouth breathing ☐ Mouth sores
☐ Nasal congestion ☐ Nasal drainage ☐ Nasal polyps ☐ Nosebleeds
☐ Post-nasal drip ☐ Sinus congestion ☐ Sneezing ☐ Snoring
☐ Sore throat ☐ Stridor ☐ Throat tightness
☐ Other (specify): _____

Speech ☐ Delay/Impediment ☐ Slurred ☐ Stuttering
☐ Other (specify): _____

Heart ☐ Chest pain ☐ Dizziness ☐ Murmurs ☐ Fainting spells
☐ Irregular heartbeat ☐ Palpitations
☐ Other (specify): _____

Lungs ☐ Chest tightness ☐ Cough-nonproductive/dry ☐ Cough productive (phlegm)
☐ Cough at night ☐ Coughing up blood ☐ Frequent bronchitis/chest colds
☐ Wheezing ☐ Shortness of breath-daytime ☐ Shortness of breath-nighttime
☐ Shortness of breath-exercise or vigorous play ☐ Low oxygen levels
☐ Other (specify): _____

GI ☐ Abdominal pain/stomach ache ☐ Bloody stool ☐ Bloating ☐ Burping
☐ Choking on food/drink ☐ Constipation ☐ Diarrhea ☐ Gassiness
☐ Heartburn/acid taste in mouth ☐ Indigestion ☐ Nausea ☐ Vomiting
☐ Regurgitation/spitting up ☐ Trouble swallowing
☐ Other (specify): _____

Feeding and Nutrition:
Do you have any concerns about your child's weight or height?
☐ Weight loss ☐ Poor weight gain ☐ Too short ☐ Too thin ☐ Overweight

Does the child have?
Difficulty feeding? ☐ Yes ☐ No Loss of appetite? ☐ Yes ☐ No
Food avoidance? ☐ Yes ☐ No

If yes, does the child avoid or refuse particular foods?

☐ Milk ☐ Egg ☐ Wheat ☐ Soy ☐ Peanut ☐ Tree nuts
☐ Fish ☐ Shellfish ☐ Others:_____

Does the child avoid certain textures or types of foods?:

☐ Soft/mushy texture ☐ Crunchy texture ☐ Bolus foods (e.g. meats/breads)
☐ Spicy foods ☐ Others: _____

Does the child cough or choke/gag when eating or drinking?

Liquids ☐ Yes ☐ No Solids ☐ Yes ☐ No
Others: _____ ☐ Yes ☐ No

Genitourinary ☐ Bedwetting ☐ Wetting pants ☐ Encoporesis (soiling pants)
☐ Frequent urination ☐ Painful urination ☐ Menses: Onset: ____ years
☐ Other (specify) _____

Muscles and Bones ☐ Fractures ☐ Back pain ☐ Joint pains ☐ Muscle pain
☐ Muscle weakness ☐ Other (specify) _____

Neurologic ☐ Concentration problems ☐ Difficulty walking ☐ Headaches
☐ Numbness ☐ Tremors ☐ Seizures ☐ Weakness
☐ Other (specify) _____

Skin ☐ Easy brusing ☐ Eczema ☐ Hair loss ☐ Hives/welts ☐ Infections
☐ Itching ☐ Lumps ☐ Rashes ☐ Other (specify) _____

Blood Diseases ☐ Anemia ☐ Easy bruising ☐ Bleeding tendency ☐ Hemophilia
☐ Sickle Cell Anemia ☐ Other (specify) _____

Sleep ☐ Excessive daytime sleepiness ☐ Difficulties falling asleep ☐ Multiple night awakenings
☐ Frequent or loud snoring ☐ Stopping breathing during sleep ☐ Morning headaches
☐ Restless sleep (kicking, jerking, twitching) ☐ Difficulty waking in the morning
☐ Discomfort or pain in legs at bedtime/during the night ☐ Other (specify) _____

MEDICATIONS

What medications does your child take?

Medication Name	Dose	Route	How Often	Description
Steroid Inhalers				
☐ Aerobid (Arrow-Bid)				gray w/a purple cap (mdi)
☐ Aerobid (Arrow-Bid)				light green w/a dark green cap (mdi)
☐ Azmacort (Asthma-Court)				white w/a white cap 7 extension (mdi)
☐ Asmanex				white w/a pink bottom ring 7 counter (twisthaler)
☐ Flovent (Flow-Vent)				orange w/an orange cap (mdi)
☐ Pulmicort (Pull-Mih-Court)				white w/bottom brown ring in a turbuhaler or flexhaler or tube

☐ Pulmicort (Pull-Mih-Court)				respules containing liquid for nebulizer
☐ Qvar				brown or burgundy depending on dose w/gray cap

Medication Name	Dose	Route	How Often	Description
Fast-acting Inhalers				
☐ Albuterol (Al-Bew-Ter-All)				white w/white cap (mdi)
☐ Ventolin (Ven-Toe-Lin)				light blue w/dark blue cap & counter (mdi)
☐ Alupent (Al-You-Pent)				clear w/blue cap (mdi)
☐ Atrovent (At-Row-Vent)				clear w/green cap (mdi)
☐ Proair (Pro-Air)				red w/white cap (mdi)
☐ Proventil (Pro-Vent-Ill)				yellow w/orange cap (mdi)
☐ Maxair (Max-Air)				light blue (autohaler)
☐ Xopenex (Zo-Pin-Ex)				light blue w/red cap (mdi)
☐ Combivent				clear w/orange cap
☐ Primatene Mist				
Long-acting Bronchodilators				
☐ Foradil (For-A-Dill)				blue cap covers a white tube w/a blue bottom. Insert pill into tube and pierce pill (aerolizer)
☐ Serevent (Sara-Vent)				green w/counter (diskus)
☐ Spiriva (Spy-Reev-Ah)				oval device gray base w/green piercing button. Need to load pill into oval device (handihaler)
Combination Medications (Inhaled Steroid and Long Acting Bronchodilator)				
☐ Advair (Add-V-Air)				purple disc w/counter (diskus)
☐ Symbicort (Sim-By-Court)				red w/gray cap (mdi)
Leukotriene Modifying Agents				
☐ Singulair (Sing-Yule-Air)				pink or tan pill
☐ Accolate (Ac-Coal-Aid)				white pill
☐ Zyflo (Z-Eye-Flow)				white pill (big)
Oral Steroids				
☐ Prednisone, Deltasone, Medrol				white pill
☐ Prelone, Pediapred, Orapred				liquid
Other Medications				
☐ Xolair (Zo-L-Air)				
☐ Allergy Shots				
☐ Intal				white w/blue cap (mdi)

☐ Tilade				white w/white cap (mdi)

Medication Name	Dose	Route	How Often	Description
Antihistamines				
☐ Allegra				
☐ Benadryl				
☐ Hydroxyzine				
☐ Clarinex				
☐ Claritin				
☐ Xyzal				
☐ Zyrtec				
Nose Spray				
☐ Saline				
☐ Astelin				
☐ Flonase				
☐ Nasacort AQ				
☐ Nasonex				
☐ Rhinocort AQ				
☐ Veramyst				
☐ Zantac/Ranitidine				
☐ Proton pump inhibitors				
☐ Epipen				
☐ Ointments				
☐ Others				

_____ _____

Parent Signature Date

_____ _____

Clinician Signature Date

Lodging

When booking reservations, please note any special allergies or cleaning requirements. Thank you.

Lodging information is provided as a courtesy to assist patients in locating facilities in the vicinity that offer reduced rates to patients. Rates and features can fluctuate so identify yourself as a National Jewish Health patient and please verify rate and pertinent information prior to making reservations. The recommendations are not an endorsement of the facilities, nor a guarantee of rates or features.

Sage Hospitality

National Jewish Health has partnered with Sage Hospitality to offer exclusive rates within a portfolio of Denver Hotels. See below.

Sage Hospitality is proud to partner with National Jewish Health and is committed to providing a successful patient experience. Sage is passionate about making a positive difference in the lives of all of our customers and committed to exceeding a patient's hotel expectations.

LODGING OPTIONS—2015

The Oxford Hotel	The Crawford Hotel Denver Union Station	Holiday Inn	TownePlace Suites Marriott	Residence Inn Marriott	TownePlace Suites Marriott	JW Marriott Denver Cherry Creek
1600 17th Street Denver, CO 80202 303.628.5400	1701 Wynkoop Street Denver, CO 80202 720.460.3700	Denver East Stapleton 3333 Quebec Street Denver, CO 80207 303.321.3500	Denver Downtown 685 Speer Blvd. Denver, CO 80204 303.722.2322	Denver City Center 1725 Champa Stree Denver, CO 80202 303.296.3444	Denver Southeast 3699 S. Monaco Pkwy. Denver, CO 80237 303.759.9393	150 Clayton Street Denver, CO 80206 303.316.2700
$180-$200 ***Jan 1-Mar 31 & Oct 1-Dec 30** **$200-$220** *** Apr 1-Oct 31**	**$239-$269** ***Jan 1-Mar 31 & Oct 1-Dec 30** **$269-$299** **Apr 1-Oct 31**	**$95.00** ***1-6 nights** **$89.00** ***7+ nights**	**$96.00-$129** ***1-29 nights** **$82-$105** ***30 + nights**	**$174 *1-4 nights** **$164 *5-11 nights** **$152 *12-29 nights** **$149 *30+ nights**	**$115-$117 *1-11 nights** **$100-$102 *12-29 nights** **$87-$90 * 30+ nights**	**$235 Weekends** **$299 Weekdays**
• 4 miles from Hospital • Complimentary 24 Hour SUV Service • 24 Hour Room Service • Non-Smoking Hotel • Laundry Service • Complimentary Wi-Fi • Fitness Center • Spa & Salon Services • Complimentary Upgrades based on availability • Pet Friendly (no deposit)	• 4 miles from Hospital • Fitness Center • Courtesy Car Service Within a 2-mile Radius • Complimentary Access to The Oxford Club, Spa & Salon Fitness Center • Evolved in-room Dining Options • In-Room Spa & Salon Services • Same Day Laundry and Dry Cleaning Service • Pet Friendly (deposit)	• 4 miles from Hospital • Complimentary Shuttle to Airport & Hospital • Onsite Restaurant & Bar • Walk to Shops & Dining • Onsite Coin Laundry • Complimentary Fitness Center, Outdoor Heated Pool, & Indoor Hot Tub • Complimentary parking • Pet Friendly • Spa Services Available	• 3.6 miles from Hospital • Complimentary Shuttle to Hospital • All Suite Hotel with Fully Equipped Kitchens • Continental Breakfast • Non-Smoking Hotel • Laundry Service • Complimentary Wi-Fi • Fitness Center • Onsite Market • Complimentary Parking onsite • Pet Friendly (deposit)	• 3.5 mile from Hospital • All Suite Hotel with Fully Equipped Kitchens • Continental Breakfast • Non-Smoking Hotel • Laundry Service • Complimentary Wi-Fi • Fitness Center • Onsite Market • Pet Friendly (deposit)	• 6.8 mile from Hotel • All Suite Hotel with Fully Equipped Kitchens • Continental Breakfast • Non-Smoking Hotel • Laundry Service • Complimentary Wi-Fi • Fitness Center • Onsite Market • Complimentary Parking	• 2 miles from Hospital • Complimentary Mercedes Service (M-F; 7-11am & 4-7PM) *Based on Availability • Onsite Dining • 24 Hour Room Service • Hypoallergenic/Natural Cleansers for Room Prep. • Non-Smoking Hotel • Complimentary Wi-Fi • 24 Hour Business Center • 24 Hour Fitness Center • Pet Friendly (no deposit)
TheOxfordHotel.com **Corporate Code:** **NATLJEWSICH**	**TheCrowafordHotel.com** **Corporate Code:** **235 NATLJE**	**histapletonhotel.com** **Corporate Code:** **NationalJewishHospital**	**Marriott.com/DenCB** **Corporate Code:** **NJWA or NJWB or NJWD**	**Marriott.com/DenRD** **Corporate Code:** **NJWA or NJWB**	**Marriott.com/DenTN** **Corporate Code:** **NJWA or NJWC**	**JWMarriottDenver.com** **Corporate Code:** **17NJWA**