Georgia Pediatric Pulmonology Associates
Little Lungs and Synagis Enrollment Form: 2011 – 2012

Include copy of Insurance/Medicaid ~~Card~~ and NICU Discharge Summary

Patient's Name _____ _____
(last) (first)

Parent's Names _____ _____
(mother) (father)

Parent's Address _____

Phone (H) _____ (W) _____ (M) _____

Primary Insurance _____ HMO PPO POS ID# _____

Secondary Insurance _____ HMO PPO POS ID# _____

Medicaid # _____ Referral # _____

About the Patient:

Date of Birth: ____/____/_____ Gestational Age: _____ weeks _____ days

Birth hospital: _____ NICU Discharge date: _____

Birth weight: _____ lb/kg Current weight: _____ lb/kg Date of weight: _____

Has this child received a Synagis injection this season? No Yes Date: _____

Risk Assessment: *Please answer all questions*

- Will the baby attend daycare after 10/1/2011?----------YES NO
- Does the baby have siblings?----------YES NO
  Dates of birth of siblings: ___/__/_____ ___/___/_____ ___/___/____
- Does the baby have neuromuscular disease?----------YES NO
  Diagnosis: _____
- Does the baby have a congenital airway abnormality? ----------YES NO
  Diagnosis: _____
- Does the baby have chronic lung disease? ---------- YES NO
  Current medications: _____ _____
  _____ _____
- Does the baby have hemodynamically significant congenital heart disease ----------YES NO
  Current medications: _____ _____
  _____ _____

Pediatrician: _____

Practice: _____ **Zip Code:** _____

Pediatrician's Phone #: ( ) _____ **Pediatrician's Fax #:** ( ) _____

Referring Physician (if different from above): _____

Telephone # and name of person completing this referral:

( ) _____ _____

Please FAX this form to: (404) 257-0337
Thank you for your referral