

A multidisciplinary clinic dedicated to the care of children with complex airways, respiratory problems and gastrointestinal disorders.

Inclusion criteria

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|---|---|--|
| <input type="radio"/> Achalasia | <input type="radio"/> Esophageal atresia (EA); including long gap | <input type="radio"/> Laryngeal atresia |
| <input type="radio"/> Airway obstruction | <input type="radio"/> Esophageal duplications | <input type="radio"/> Laryngeal cleft |
| <input type="radio"/> Apnea (central and obstructive) | <input type="radio"/> Esophageal replacement; colonic interposition | <input type="radio"/> Laryngeal web |
| <input type="radio"/> Bronchogenic cysts | <input type="radio"/> Gastroesophageal reflux with associated respiratory problems | <input type="radio"/> Laryngomalacia (severe) |
| <input type="radio"/> Bronchomalacia | <input type="radio"/> Glottic stenosis | <input type="radio"/> Sleep disorders |
| <input type="radio"/> Bronchopulmonary dysplasia | <input type="radio"/> Hypoplastic lung | <input type="radio"/> Subglottic stenosis |
| <input type="radio"/> Caustic ingestion with stricture | <input type="radio"/> Hypoventilation | <input type="radio"/> Tracheal stenosis |
| <input type="radio"/> Chronic aspiration (tracheotomy dependent) | <input type="radio"/> Interstitial lung disease | <input type="radio"/> Tracheoesophageal fistulas (TEF) |
| <input type="radio"/> Craniofacial syndromes (airway obstruction/ feeding problems) | <input type="radio"/> Laryngeal/tracheal/bronchial papillomatosis (sexually transmitted infections) | <input type="radio"/> Tracheomalacia |
| <input type="radio"/> Dysphagia | | <input type="radio"/> Vocal cord paralysis |
| | | <input type="radio"/> Voice disorders |

If your patient doesn't meet the above criteria, they will be reflexively referred to our pulmonology specialists.

Use our paperless portal to send referrals at epiccarelink.cookchildrens.org Date: _____

Patient name: _____ DOB: _____

Address: _____

Guardian name: _____

Contact numbers: Work: _____ Home: _____ Mobile: _____

Referring physician: _____

Physician phone: _____ Physician fax: _____

Primary insurance information attached

Preferred language: _____ Preferred office location: _____

Referral coordinator name: _____

Coordinator phone: _____ Coordinator fax: _____

Reason for referral

Please note the specific problem. If this is an urgent referral, please call the specialty requested.

Physician signature: _____ Date: _____

When you fax this form, please include a copy of the patient's insurance card, labs, imaging, history and patient demographics. Please attach any prior procedures or studies that include bronchoscopy, CT, MRI, US, swallow function study, DLB, EGD, esophagram, UGI and/or a sleep study.

Cook Children's Aerodigestive Clinic

1500 Cooper St., Second Floor | 682-303-3350 phone | 8 a.m.-5 p.m., Mon-Fri
 Fort Worth, TX 76104 | 682-303-3351 fax | cookchildrens.org

If this is an urgent referral, please call our clinic directly.