Children's Hospital of The King's Daughters Health System

ENT Referral Summary
Fax to (757) 668-7708 or email to entreferral@chkd.org

Referring physician _____

Name of patient _____DOB_____MR#_____

Reason(s) for referral (check all that apply):

___ 1. Recurrent otitis media ____ separate episodes over ____ months

___ 2. Chronic otitis media Bilateral effusion for ____ months *or*

Unilateral effusion for ____months

___ 3. Recurrent tonsillitis ____ documented episodes over ____ months

Symptoms include (circle all that apply):

A. Fever to ____^{o}F

B. Tonsil exudate

C. Adenopathy > 1.5cm

D. Positive strep culture

___ 4. Obstructive adenotonsillar hyperplasia

(Please have parents prepare a recording to bring with them if possible)

___ 5. Neck Mass Present for ____ months

Location ___Central ____Right ____Left

___ 6. Stridor/Noisy Breathing Present since age _____

_____ History of Intubation

___ 7. Nasal Obstruction/Snoring Present for ____ months

___ 8. Hearing loss _____Passed Newborn Hearing Screening

_____History of prematurity

_____9. Hoarseness Present for ____ months

_____10. Rhino-sinusitis _____Documented episodes over _____months

_____ Allergic rhinitis_____ Formal allergy testing

____11. Other _____