VASCULAR ANOMALIES CENTER

Patient Intake Form
Phone: (832) 822-3800 Fax: (832) 825-9500
e-mail: vascularanomalies@texaschildrens.org

Texas Children's Hospital®

*** THIS FORM CAN BE COMPLETED BY A PARENT OR PHYSICIAN ***
*** COMPLETED REFERRALS WILL BE REVIEWED WITHIN 5 BUSINESS DAYS ***
IF SUBMITTED BY A PHYSICIAN, PLEASE INCLUDE THE CLINIC FACE SHEET WITH THE PATIENT'S DEMOGRAPHIC INFORMATION

DATE OF REQUEST: _____ COMPLETED BY: _____ TCH MRN: _____

PATIENT INFORMATION (PLEASE PRINT AND FILL OUT ALL BLANKS COMPLETELY)

Last Name	First Name & MI	Age	Date of Birth	☐M ☐F

Home Address (Street)	City, State and Zip		

Interpreter needed? ☐ Yes ☐ No If yes, what language? _____

Parent/Guardian(s)	Home Phone (check preferred)	Work Phone	Cell Phone
	☐	☐	☐

Referring Physician Name (PCP and/or Subspecialist)

Practice Contact	Office Phone	Office Fax

CLINICAL INFORMATION (OVERVIEW OF VASCULAR ANOMALY)

My child's vascular anomaly is located:

	Left	Right	Both
Head and/or neck	☐	☐	☐
Upper extremity	☐	☐	☐
Lower extremity	☐	☐	☐
Trunk and/or abdomen	☐	☐	☐

IF SKIN INVOLVEMENT OR DISCOLORATION PRESENT, PLEASE SUBMIT A PHOTO.

My child's vascular anomaly first appeared?
- ☐ on a prenatal exam
- ☐ at birth
- ☐ within 1 month of birth
- ☐ within 1 year of birth
- ☐ at _____ years of age

Since then, the vascular anomaly has:
- ☐ become smaller
- ☐ stayed the same
- ☐ become larger

Does your child have a specific diagnosis? (Check all that have been told to you.)
- ☐ Hemangioma
- ☐ Arteriovenous malformation
- ☐ Lymphatic malformation/Lymphangioma
- ☐ Capillary lymphatic venous malformation (Klippel-Trenaunay Syndrome)
- ☐ Port wine stain (capillary malformation)
- ☐ Venous malformation
- ☐ Vascular tumor
- ☐ Other: _____

At what age was this diagnosis made: _____

Who made this diagnosis?
☐ Pediatrician ☐ Other Medical Doctor ☐ Family Member ☐ Friend ☐ Other: _____

Does your child experience any discomfort with the vascular anomaly? ☐ Yes ☐ No

Does your child require pain medication? ☐ Yes ☐ No

If yes, what pain medications do you give your child? ☐ Tylenol® ☐ Motrin® ☐ Prescription drugs

How much? _____ How often? _____ Does it work? ☐ Yes ☐ No

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CLINICAL INFORMATION (CONTINUED)

TREATMENT/EVALUATION Patient Name: _____

Has your child ever received treatment for his/her vascular anomaly? ☐ Yes ☐ No

Treatment	*Please include details such as medication name, course, surgical details, etc.*	*Date(s)*	*Results*
Medication			
Sclerotherapy			
Embolization			
Laser			
Surgery			

Has your child had any complications from previous therapy? ☐ Yes ☐ No
If yes, describe: _____
Has your child ever been treated at Texas Children's Hospital for any condition? ☐ Yes ☐ No ☐ Unsure
Has your child ever been hospitalized for his/her vascular anomaly? ☐ Yes ☐ No
If yes, describe: _____

Has your child had any of these procedures to evaluate his/her anomaly?

Test/Procedure	*Date(s)*	*Location/Facility*	*Results (if known)*
MRI			
CT Scan			
Ultrasound			
X-Ray			
Angiogram			
Other			

Are any other family members affected by a vascular anomaly? ☐ Yes ☐ No
If yes, describe: _____
Does your child have other medical problems? ☐ Yes ☐ No
If yes, describe: _____

My child has experienced problems with:

	Never	*Past*	*New*	*Unknown*		*Never*	*Past*	*New*	*Unknown*
Bleeding	☐	☐	☐	☐	Poor Growth	☐	☐	☐	☐
Easy Bruising	☐	☐	☐	☐	Problems with Spinal Cord	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	Recurrent Infections	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Respiratory Problems	☐	☐	☐	☐
Hearing Problems	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	Skin Rashes	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	Swelling	☐	☐	☐	☐
Lack of Appetite	☐	☐	☐	☐	Tracheotomy	☐	☐	☐	☐
Limb Deformity/Limping	☐	☐	☐	☐	Ulcerations	☐	☐	☐	☐
Pain	☐	☐	☐	☐	Visual Problems	☐	☐	☐	☐
Pale Skin	☐	☐	☐	☐	Weight Loss	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐