**Georgia Pediatric Pulmonology Associates**
**Little Lungs and Synagis Enrollment Form: 2009 – 2010**

**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 10/1/2009?----------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☐

*If you have any questions about these risk factors, please contact our Synagis Coordinator at (404) 252-7339 ext 1021.*

**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**