Children's Hospital of Philadelphia

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Acquired Autonomic Dysfunction Program: New Patient Intake Form

All Required Fields are in **RED**

Name	DOB AGE:
Address	Best phone #
Email:	**Referred by:** (How did you hear about our Program?) Select
If referred by a physician, please list: Specialty Facility/Practice Name	

1. **Please provide typed summary describing the events that have led up to your child's symptoms and how they have impacted your child's life.**
   - This will give the providers a better understanding as to what is happening, from YOUR point of view
   - Please list your child's symptoms and when they began
   - Medical records are only one part of the story
   - Please upload through MyCHOP

2. **Has your child been diagnosed with autonomic dysfunction/POTS?** **Yes** ◉ **No** ○
   If yes, When? **By Whom?**

3. **Please list your child's top 3-5 symptoms that he/she struggles with the most:**

   a.

   b.

   c.

   d.

   e.

4. **Is your child missing school/classes due to symptoms?** Select

   If yes, please describe, how often?

5. **Please list the medication (only name) your child is currently taking, including herbal supplements, vitamins, etc.) :**

Please list any specialists (including Primary Care Physician), who your child has seen:

Name of specialist	Type of Specialist	Health System	Last Seen: Month/Year
	Primary Care Provider		

Please obtain all Non-CHOP medical records, lab results, reports and images:

We cannot schedule your child any appointments until we review the completed intake form, all medical records, drafted (typed) summary, and tests.

Please email back to AADPRecords@email.chop.edu, upload via MyCHOP, or fax to 215-590-3198(Attn: Cheryl)

Tests/Studies	Health System	Month/Year
EKG		
Echocardiogram		
Holter		
Blood Test		
MRI/MRA		
CT Scan		
Neuropsychological Testing		
IEP		
Educational Testing		
Vestibular Testing		
Sleep Study		
EEG		
Ultrasound		
Endoscopy		
Hydrogen Breath Test		
Gastric Emptying Study		
Pulmonary Function Test		
GI Manometry Studies		

Please provide your drafted summary below (Refer to #1 for direction):

Checklist for AADP Records For Patients/Families (Please keep for your own use)

Fax: Attn Cheryl 215-590-3198
Email: AADPrecords@email.chop.edu

Studies Checklist	Sent	Medical Records Checklist	Sent
EKG (**strip** and report)		Primary Care Provider	
ECHO (**images** and report)		Cardiology	
Holter (**images** and report)		Neurology	
Lab studies /Blood tests		Gastroenterology	
MRI (**images** and report)		Physical Therapy	
MRA (**images** and report)		Psychiatry	
CT Scan (**images** and report)		Endocrinology	
Neuropsychological Testing		Rheumatology	
School IEP		Allergy	
Educational Testing		Pulmonary	
Vestibular Testing			
EEG			
Sleep Study			
Ultrasound			
Endoscopy			
Colonoscopy			
Gastric Emptying Study			
Hydrogen Breath Test			
GI Manometry Studies			
Pulmonary Function Test			