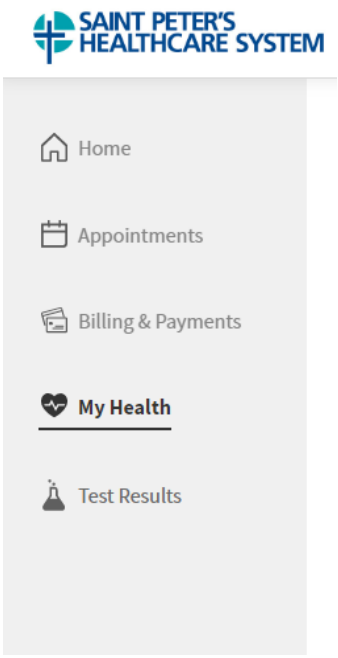
THE CHILDREN'S HOSPITAL
AT SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

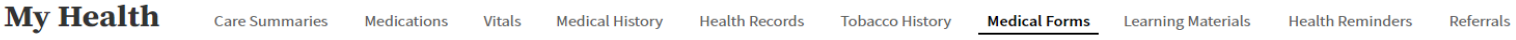
PLEASE COMPLETE THIS FORM AND ATTACH IT TO THE SAINT PETER'S PORTAL BEFORE YOUR CHILD'S CLINIC VISIT

A. Please sign in to your child's Saint Peter's portal account.

B. Click on **My Health** tab on the left side of the main page



C. Click on **Medical Forms** to the right of **My Health** button (7th button to the right)



D. Look for **Pediatric Endocrinology New Patient Intake Form in Spanish**

E. Please print the form

F. After completing the form, please scan and upload to the Patient Portal at least 2 days before the clinic visit.

G. The form can be uploaded in the Messages section of the portal by clicking on the **Attach Files tab**

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PLEASE ENSURE THAT THIS FORM IS READ IN ITS ENTIRETY IT CONTAINS PERTINENT INFORMATION REGARDING YOUR CHILD'S VISIT!

Saint Peter's University Hospital Pediatric Specialty Service
Pediatric Endocrinology Department
254 Easton Avenue, 3rd Floor
New Brunswick, New Jersey 08901

Dear Parent or Guardian:

Your child, _____, has an appointment on _____ with Dr. _____ at the Pediatric Endocrinology/Diabetes Self-Management Education Program located at Saint Peter's University Hospital. We look forward to seeing you then.

We are part of the Saint Peter's University Children's Hospital and are affiliate with Rutgers University/Robert Wood Johnson Medical School and Children's Hospital of Philadelphia (CHOP). Since one of our functions is to train future pediatricians, your child may be seen by a pediatric resident or medical student as well as by Dr. _____.

Enclosed are a map and directions to help you find our office. Parking is sometimes challenging, so please allow 30 minutes to park, check into the building and for registration. Valet parking is also available

It is the responsibility of the parent/guardian to get necessary referrals and medical records (see the attached checklist).

We would appreciate it you are unable to keep this appointment to please contact us as soon as possible so another family can be given the spot. Families who do not keep the appointment or do not cancel at least 24 hours ahead of the scheduled appointment may not be given another appointment. Your referring physician will be notified.

If you have any questions or concerns before the appointment, please call the office at 732-745-8574. And thank you for choosing Saint Peter's!

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Saint Peter's University Hospital Pediatric Specialty Service
Pediatric Endocrinology Department
254 Easton Avenue, 3rd Floor MOB, New Brunswick, New Jersey 08901

Please ask your primary care provider (PCP) to fax the following information to732-514-1956 for the doctor to review. We recommend that you bring a copy to the visit too:

- ☐ All previous heights and weights and growth charts (ESSENTIAL)
- ☐ Medical records
- ☐ Laboratory test results
- ☐ Radiology (X-rays, ultrasounds, etc.) reports
- ☐ Radiology films or CD (they must be requested by the parent/guardian)
- ☐ First Interview Visit Form completed by parent/guardian (attached). Once complete, please upload to the Saint Peter's patient portal. Please bring a copy to the visit too in case we did not receive them directly.

Please bring the following information for registration:

- ☐ Referring PCP's name, address and phone number (attached)
- ☐ Insurance identification card(s)
- ☐ Identification of parent / guardian. All children under the age of 18 must be accompanied by a parent or legal guardian
- ☐ HMO recipients, please bring a referral for office visit
  or PPO recipients, please bring a prescription from PCP
- ☐ Diabetes self-management education referral for certified diabetes educator and nutrition visit
- ☐ If applicable, a referral for laboratory services

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Pediatric Endocrinology
254 Easton Avenue, New Brunswick, New Jersey 08901

FIRST VISIT INTERVIEW

Name_____ Age_____ Referred by_____

Unit Number_____ Date of Birth_____ Date of Visit_____

Please complete Questionnaire:

Why was your child referred to our office?_____

How long has your child had this problem?_____

Are there any other symptoms or complaints?_____

Has your child experienced any of the following:

PROBLEMS	No	YES	If YES PLEASE DESCRIBE
Headaches			
Visual Disturbances			
Dizziness			
Seizure			
Vomiting			
Abdominal Pain			
Constipation			
Diarrhea			
Heat or Cold Intolerance			
Sleep Disturbances			
Excessive Urination			
Excessive Drinking			
Painful Urination			
Bed Wetting			
Joint Pain			
Other			

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Dietary Intake (Pease complete attached food log)

How would you describe your child's eating habits?_____

How would you describe your child's personality?_____

School Grade:_____

How is your child doing in school:_____

Past Medical History (circle or fill in the blanks):

Born Full Term or Premature?: (____ weeks) Normal Vaginal Delivery / Caesarean Section:

Was the pregnancy normal or complicated (describe)?:_____

Did Mom take any medications during pregnancy?:_____

Were there any problems during delivery?:_____

Birth Weight_____pounds _____ ounces Length_____ inches

Any problems in the nursery?:_____

Your child was born at_____Hospital. Length of stay_____

How old was your child when he / she:

sat without support _____ walked_____ talked_____

has first tooth _____ permanent teeth_____

Did your child have any hospitalizations, surgeries or significant illnesses in the past?:

_____

_____

_____

Age when he / she developed

Breasts_____ Pubic Hair_____ Axillary hair_____ Menses_____

None of the above_____

Is he / she taking any medications? (If yes, please list):_____

_____

Does your child have any allergies to medication (Y / N) If yes, please list:

_____

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Family History	Age	Height	Weight	Health	Age of Puberty
Father					
Mother					
Sibling #1. Boy Girl					
Sibling #2. Boy Girl					
Sibling #3 Boy Girl					
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					

Is there anyone in the family with diabetes, thyroid problems, growth problems, obesity or any other significant medical problem? If yes, please write below.

Medical Condition	Diabetes	Thyroid	Growth	Overweight or Obesity	Heart disease	High blood pressure	High cholesterol	Other
Father								
Mother								
Sibling #1. Boy Girl								
Sibling #2. Boy Girl								
Sibling #3 Boy Girl								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Maternal aunt / uncle								
Paternal aunt / uncle								
Maternal cousins								
Paternal cousins								
Other relatives:								

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Division of Pediatric Endocrinology
Third Floor - Medical Office Building
254 Easton Avenue
New Brunswick, New Jersey 08901

Office Number: (732) 745-8574
Fax Number: (732) 514-1956

PRIMARY CARE PHYSICIAN INFORMATION

Name of Child:_____ Medical Record Number_____

Name of Group:_____

Name of Primary Care Physician:_____
(First name) (Last name)

Street Address _____

_____

Phone Number _____

FAX Number _____

ANY CHANGES REGARDING YOUR CHILD'S PRIMARY CARE PHYSICIAN SHOULD BE REPORTED IMMEDIATLEY TO OUR OFFICE!

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What Does Your Child Eat?

It is important for us to know exactly what your child eats so that we can assess the calories, protein and overall nutrient. This is especially important if you child is not gaining weight properly, therefore, we need to determine the cause.

Please record all foods and beverages that your child takes throughout 3 typical days of eating and drinking. Include all beverages, nighttime bottles and all meals / snacks. Do not record any days when your child is ill.

Under the comment section, please record information such as refusal to eat, nausea, vomiting, did not tolerate, diarrhea, and activity that may have an impact on what was eaten.

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RECORD FOR 3 DAYS

DAY ONE			
Date / Time	Food	Amount	**Comment**

DAY TWO			
Date / Time	Food	Amount	**Comment**

DAY THREE			
Date / Time	Food	Amount	**Comment**