Lancaster Cleft Palate Clinic

NEW PATIENT REFERRAL SHEET

DATE: ___________________

PATIENT'S NAME: ____

PARENT'S NAME: ____

ADDRESS: ____

CITY: ____________________ STATE: ____________ ZIP CODE: __________

BIRTHDATE: _______________PHONE (H): _____________ (W): ___________

INSURANCE INFORMATION: ____

SOURCE OF REFERRAL: ____

ADDRESS: ____

REASON: ____

FAMILY PHYSICIAN OR PEDIATRICIAN: ______________________________

PLASTIC SURGEON (S) LIP: _______________________________________

PALATE: _______________________________________

NOSE: _______________________________________

HAS PATIENT HAD ANY OF THE FOLLOWING REMOVED?

TONSILS? __________ DATE OF REMOVAL? ___________

ADENOIDS? __________ DATE OF REMOVAL? ___________

MYRINGOTOMY?__________ DATE OF REMOVAL? ___________

APPOINTMENT DATE: __________________________TIME: ______________

DOCTORS: ____

NOTES MISC: ____