UFHealth PHYSICIANS

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Pediatric Referral Form

(Printed Electronic forms can be substituted for patient and referring information)

Patient's Name_____ **Date of Birth**_____

Parent/Guardian Name_____ **Phone Number**_____

Insurance _____ **(must include appropriate referral/authorization to schedule)**

Referring Physician_____ **Phone #**_____

Referring Physician Address_____

We must have the information outlined below to process your referral. Please forward office records to support that the criteria listed below has been met for the more common diagnosis. Please do not send notes that do not pertain to the condition for which you are seeking evaluation.

☐ **Otitis Media/Evaluation for Tympanostomy Tubes** (supporting documentation summarizing dates of infections and antibiotics prescribed must accompany the referral to schedule. If a summary is not available, please list the date and antibiotics prescribed below)

Criteria for referral: 3 antibiotics in the past 6 months or 4 in the past year with one in past 6 months-OR-Rocephin in the past 3 months.

1._____ 2._____ 3_____ 4_____

☐ **Tonsil and Adenoid Evaluation** (supporting documentation summarizing the dates of infections must accompany the referral to schedule)

Criteria for referral: 1. Presence of chronic snoring greater than 3 months along with witnessed gasping, pauses or irregular sleep –OR-

2. Positive Sleep Study for Obstructive Sleep Apnea (please send the sleep study results) –OR-

3. Presence of recurrent Strep throat or tonsillitis: 7 documented infections within the past 12 months or 5 infections per year for the past 2 years, or 3 infections per year for the past 3 years.

☐ **Allergic Rhinitis Evaluation** (supporting documentation summarizing treatment must accompany the referral to schedule)

Criteria for referral: Failed 1st line medical therapy with oral anti-histamines AND nasal steroid sprays x 10 weeks minimum and have been evaluated by Allergy Medicine. Then refer ONLY IF there is a concern for persistent anatomical obstruction. Patients should only be referred when surgical treatment may be the only option left to consider.

☐ **Epistaxis Evaluation** (supporting documentation supporting treatment must accompany the referral to schedule)

Criteria for referral: Suggestions for what we have found works well for most patients:
1) Mupirocin to both nostrils / septum bid to tid for two weeks, then switch to Vaseline at night.
2) Saline mist and spray
3) Humidifier to bedside
4) If there is concern for a bleeding disorder; work up / lab testing

☐ **Failed Hearing Screening** (supporting documentation must accompany the referral to schedule)

Criteria for referral: 1. Refer first to Audiology for a formal Audiogram

2. If Audiogram is abnormal, refer to ENT (a copy of the Audiogram must accompany the referral)

☐ **Tongue Tie/Ankyloglossia Evaluation** (respective reports must accompany the referral to schedule) (*Lip ties should be referred to OT*)

Criteria for referral: Any child over 4 months old needs to have been evaluated by a Speech Pathologist or Lactation Consultant recommending surgical necessity.

☐ **Other (please clearly specify the reason for the referral and send supporting documentation summarizing any treatment)**

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Thank you for choosing our team at UF Health Ear, Nose and Throat Specialties for your patient's health care needs!