Appointment Request and Clinical Triage Form

Division of Adolescent Medicine, Medical University of South Carolina

Referral Type (check one): ☐Urgent ☐Routine ☐Elective

Referring MD/Office: _____

Patient's Name: _____ DOB: _____/_____/_____

Parent/Guarantor's Name: _____

Insurance: _____

CLINICAL INFORMATION
*Eating disorder referrals, please include current vital signs
Date: _____ Height: _____ Weight: _____
Heart Rate: _____ Pulse: _____
Temperature: _____
Blood Pressure: _____ ☐Laying ☐Sitting ☐Standing (Check one)

REASON FOR REFERRAL: CHECK ALL THAT APPLY

☐Abnormal Weight Loss
☐Amenorrhea
☐ Anorexia Nervosa
☐Anxiety
☐ Bulimia
☐ Chronic Fatigue
☐ Contraceptive Management
  ☐Nexplanon
  ☐ General contraceptive management
☐ Depression
☐ Dysfunctional Uterine Bleeding
☐ Dysmenorrhea
☐Irregular Menses
☐ Malnutrition
☐ Menorrhagia
☐ Menstrual Disorder
☐ Mood Swings
☐Ovarian Cyst
☐ Pelvic Inflammatory Disease
☐ Polycystic Ovarian Syndrome
☐ Vaginal Discharge
☐ Obesity - Pediatric Obesity Evaluation Management
☐ Other_____

Please attach relevant medical information or records. For eating disorder related referrals, please attach growth chart and any recent lab work.

Lab work for eating disorder referrals (check all included): ☐CBC BMP including Ca++ Mg Phos Hepatic Function Panel 25 OH-Vitamin D TSH Prealbumin

Lab work for Pediatric Obesity Evaluation Management (POEM) Clinic(completed within 6 months of appointment date): CBC CMP Fasting Lipid Insulin Hgb A1c Vitamin D

PLEASE FAX COMPLETED FORM TO 843-876-1493
or call Children's Services at 843-876-0444, Option 1