LYMPHATIC CENTER REFERRAL/ EVALUATION FORM

Patient Name: _____ Date of Birth: _____

Parent(s)/Guardians(s): _____

Address: _____

Phone Number: (Home)_____(Cell)_____

E-mail Address: _____Primary language: _____

Referring Physician: _____

Address: _____

Phone Number: _____(fax)_____

E-mail Address: _____

Primary Care Provider: _____

Address: _____

Phone Number: _____(fax)_____

E-mail Address: _____

SocialWorker/CaseManager:_____

Phone Number: _____(fax)_____

E-mail Address: _____ _____

TREATMENT/MEDICAL SUMMARY

☐ Copy of front and back of insurance card if available (please enlarge)
☐ Physician referral-letter with comprehensive treatment summary to date.
☐ Allergies
☐ List of current medications
☐ Central access. (Port a cath, Single Lumen or Double Lumen CVL/ Vascath) Op Report or Imaging report to confirm CVL placement (if applicable)
☐ Pulmonary Function Testing

RADIOLOGY

☐ CT, MRI Scans, lymphangiograms, IR Procedures, Cardiac catheterizations ON DISC and REPORTS (from initial diagnosis-final images **DICOM** images only)

LABORATORY

☐ Most recent CBC, BMP, fecal alpha-1 antitrypsin, LFT's, Albumen, any chylous fluid analysis (cell counts, differentials, chylomicrons, TG)

Please Email or Fax **RECORDS/FORMS** TO:
Attn: Lissa Carter, PA
Div of Interventional Radiology
Dept of Medical Imaging
Elisabeth.Carter@nemours.org
Theresa.Callahan@nemours.org
FAX (302) 651-6859

All Imaging Studies on DISCS can be OVERNIGHTED VIA
UPS or FedEx to (please send tracking #):
AI Dupont Hospital for Children
Attn: Lissa Carter PA-C
Dept of Medical Imaging, Div of Interventional Radiology
1600 Rockland Rd
Wilmington, DE 19803