UT Lysosomal Storage Disease Center

Dr. Kartik Venkatachalam, Director
Dr. Mary Kay Koenig, Co-Director
Dr. Hope Northrup, Co-Director

Phone: 713-500-7177 ⋮ Fax: 713-500-0719 ⋮ Website: www.utlyso.org ⋮ email: utlyso@uth.tmc.edu

Thank you for your interest in the UT Lysosomal Storage Disease Center. Please complete the following paperwork. The paperwork may be returned by mail, fax, or email.

Mailing Address – Please note that this is NOT where appointments are held

The UT Lysosomal Storage Disease Center
6410 Fannin Street, Ste. 732
Houston, TX 77030

Fax- 713-500-0719

Email- utlyso@uth.tmc.edu

Once the following forms are completed and returned, an appointment may be scheduled:

- ☐ Patient Information Form
- ☐ Photo/Video Consent
- ☐ Email Consent
- ☐ Physician Contact Form
- ☐ Complete Physician List
- ☐ Medical Records Release Form
- ☐ Medication List
- ☐ Diet Information

Patient appointments are at:
UT Professional Building
6410 Fannin St. Suite 500 (Specialty Pediatrics)
Houston, Tx 77030

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PATIENT INFORMATION PLEASE PRINT LEGIBLY. PLEASE GIVE YOUR NAME AS IT APPEARS ON YOUR INSURANCE CARD.			
Last name	First name	Middle name	
Street address	City	State	Zip code
Home phone	Cell phone	Email Address	
Date of birth (mm/dd/yy)	Ethnicity/Race	Male ☐	Female ☐
Biological Mother's name Date of Birth	Biological Father's name Date of Birth	Phone	

WHO IS SENDING YOU TO SEE US? Please print legibly. Please fill in information to the best of your knowledge.			
Full name of referring physician	Specialty		
Street address	City	State	Zip code
Office phone	Office fax		

INSURANCE INFORMATION Please print legibly. Please fill in information as accurately as possible. Information on front of your card.			
Insurance provider	Insurance ID #	Insurance group #	
Insurance claims address (located on the back of your insurance card)			
City	State	Zip code	Provider phone (usually on the back of your card)

Insurance Subscriber (if not above patient) Last name	First name	Middle name	
Street address	City	State	Zip code
Home phone	Work phone	Cell phone	
Date of birth (mm/dd/yy)	Social Security #	Relationship to patient	

UTHealth
The University of Texas Health Science Center at Houston
Medical School

Children's Memorial Hermann Hospital

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VIDEO/PHOTO CONSENT FORM

In consideration of the purposes, objectives, and work of the University of Texas-Houston Medical School, Department of Pediatrics, Division of Child Neurology, I (We) the undersigned, hereby grant permission to The University of Texas-Houston Medical School, Department of Pediatrics, Division of Child Neurology, to photograph and/or videotape me/my child.

I hereby grant full permission to The University of Texas Medical School at Houston, Department of Pediatrics, Division of Child Neurology to conduct such photography and/or videotaping for the purposes of clinical decisions, research or education. My consent and permission will remain in effect until revoked by me in writing.

I have read the above statement and give my consent and have had the opportunity to ask questions regarding this permission.

______________________________ ______________________________

Patient Name D.O.B.

______________________________ ______________________________

Patient/Parent Signature Date

______________________________ ______________________________

Witness Date

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CONSENT FOR USE OF ELECTRONIC COMMUNICATIONS IN THE MEDICAL CARE OF:

_____________________________ (patient).

In consideration of the purposes, objectives, and work of the University of Texas-Houston Medical School, Department of Pediatrics, Division of Child Neurology, I (We) the undersigned, hereby grant permission to The University of Texas-Houston Medical School, Department of Pediatrics, Division of Child and Adolescent Neurology, to communicate via email concerning me/my child. All Email communications should be directed to ____(email address).

I hereby grant full permission to The University of Texas Medical School at Houston, Department of Pediatrics, Division of Child and Adolescent Neurology to use this form of communication and understand the inherent risks associated with its use. I understand that Email is not secure and it is possible that mine or my child's person medical information may be accessed by others. The University of Texas-Houston Medical School will do everything in their power to avoid unauthorized access of this material. My consent and permission will remain in effect until revoked by me in writing.

I have read the above statement and give my consent and have had the opportunity to ask questions regarding this permission.

_____________________________ _____________________________
Patient Name D.O.B.

_____________________________ _____________________________
Patient/Parent Signature Date

_______________________ _______________________
Witness Date

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Current Physician Contact Information

Pediatrician/Primary Care

Name: ____________________________

Address: __________________________

City/State/Zip: ____________________

Phone: ____________________________

Fax: ______________________________

Pharmacy

Name: ______________________________

Address: ___________________________

City/State/Zip: _____________________

Phone: _____________________________

Fax: _______________________________

Gastroenterology (GI)

Name: ____________________________

Address: __________________________

City/State/Zip: ____________________

Phone: ____________________________

Fax: ______________________________

Ophthalmology

Name: ______________________________

Address: ___________________________

City/State/Zip: _____________________

Phone: _____________________________

Fax: _______________________________

Immunology

Name: ____________________________

Address: __________________________

City/State/Zip: ____________________

Phone: ____________________________

Fax: ______________________________

Endocrine

Name: ______________________________

Address: ___________________________

City/State/Zip: _____________________

Phone: _____________________________

Fax: _______________________________

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Nephrology

Name: ________________________

Address: _______________________

City/State/Zip: ___________________

Phone: _________________________

Fax: ___________________________

Cardiology

Name: ____________________________

Address: __________________________

City/State/Zip: ______________________

Phone: ____________________________

Fax: ______________________________

School Information

Name: ________________________

Address: _______________________

City/State/Zip: ___________________

Phone: _________________________

Fax: ___________________________

Notes: _________________________

Other

Name: ____________________________

Address: __________________________

City/State/Zip: ______________________

Phone: ____________________________

Fax: ______________________________

Notes: ____________________________

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Complete Physician List – Patient Name ______________________________

Please fill out information for all current and prior physicians that have contributed to your child's medical care from birth to present. Include physician's full name and contact information.

Primary Care Physicians	Endocrinology
Neurology	ENT
Genetics	Immunology
Gastroenterology	Nephrology
Pulmonary	Hematology
Cardiology	Others (list specialty)
Inpatient Hospitals	Outpatient Hospitals

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Request and Authorization for Medical Records

The patient indicated below has authorized us to release a copy of his/her **complete medical records** (birth to present). Below is a signed authorization for release of information.

Your prompt reply in getting these records to our office will facilitate us providing the patient with continual care. Thank you for assisting us in this matter.

I hereby request and authorize that:

Name of clinic, doctor's office, hospital ___________________________________
Address ___________________________________
City, State, Zip code ___________________________________
Phone ___________________________________
Fax ___________________________________

Convey to the University of Texas Health Services (UTHS) all medical information, unless otherwise noted, on my treatment at your facility. The question of privacy between you and your institution, my attending physicians, UTHS and myself is waived. This authority is extended to the furnishing of copies of all or any desired parts of this medical record.

Patient Name:__________________________ Patient DOB _______________

Home Address __________________________ Patient SS# _______________
____

Patient/Legal Guardian Signature __________________________ Date ______________

Please send my records to:
UT Lysosomal Storage Disease Center
6410 Fannin Street Ste. 732
Houston, Texas 77030
Fax: 713-500-0719 * If less than 50 pages*
Phone: 713-500-7164

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Name:_____________________________________ Date: ___________________________________

Medication Allergies: ____

MEDICATIONS- Please include any vitamin supplements.

Medication	Dose	Frequency (Daily, 2 X a day, etc)

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DIET

☐ Regular Diet, No Restrictions

☐ Regular Diet with Restrictions:

____

____

Tube Feedings   Formula: ____

☐ G-tube

☐ J-tube

☐ Bolus

________ cc EVERY ________ hours

☐ Continuous

________ cc per hour for ________ hours per day

Food Allergies:

____

____

Drug Allergies:

____

____