Congenital Cytomegalovirus (cCMV) Infectious Disease Clinic

Provider referral form

Complete this form and fax it along with birth, lab and clinic records to 404-785-9098.

Scheduling: Call 404-785-1979 to speak with the cCMV infectious disease operations coordinator.

Clinical questions: Call 404-785-3627 and request to speak with the on-call infectious disease clinician for questions related to patient care.

Patient demographics

Patient Name: _____ Age: _____ Date of Birth: ___/___/___

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Guardian Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell: _____ Email: _____

Referring Provider Name: _____ Date of Referral: _____ /_____ /_____

Direct Contact Phone Number for Referring Provider: _____

Primary Care Provider Name: _____ Phone: _____

Has the guardian been informed of the cCMV diagnosis? O Yes O No O Unknown

Newborn history

Birth Hospital Name: _____ City: _____ State: _____

Sex Assigned at Birth: O Male O Female Gestational Age at Birth (in weeks): _____

Birth Weight (units and % if known): _____ Length (units and % if known): _____

Head Circumference (units and % if known): _____ Neonatal Nutrition: O Human Milk O Infant Formula

Prenatal diagnosis/concern for CMV: O Yes O No O Unknown Describe: _____

Initial Hearing Screen (REQUIRED):

Date: _____ /_____ /_____

Left Ear: O Pass O Fail O Referred

Right Ear: O Pass O Fail O Referred

Follow-up Hearing Screen:

Date: _____ /_____ /_____

Left Ear: O Pass O Fail O Referred

Right Ear: O Pass O Fail O Referred

Additional Hearing Assessments:

Test:

Date: _____ /_____ /_____

Left Ear: O Pass O Fail O Referred

Right Ear: O Pass O Fail O Referred

CMV Diagnostic Testing:

Source of Specimen: O Saliva

Date Collected: _____ /_____ /_____

Result: _____

Source of Specimen: O Urine

Date Collected: _____ /_____ /_____

Result: _____

Additional CMV Diagnostic Testing:

Source of Specimen: O Blood

Date Collected: _____ /_____ /_____

Result: _____

Symptoms Suggestive of cCMV:

Microcephaly: O Yes O No

IUGR: O Yes O No

Hepatosplenomegaly: O Yes O No

Jaundice: O Yes O No

Rash/Petechiae: O Yes O No

Cholestasis: O Yes O No

Seizures: O Yes O No

Other: _____

Other pertinent information: _____

Care requested

Infectious Disease Consult at Children's O Yes O No

Comments: _____

If previously performed or currently scheduled, note date and/or result: _____

ENT or Audiology Consult at Children's O Yes O No

Comments: _____

If previously performed or currently scheduled, note date and/or result: _____

Ophthalmology Consult at Children's O Yes O No

Comments: _____

If previously performed or currently scheduled, note date and/or result: _____

Cranial Ultrasound at Children's O Yes O No

Comments: _____

If previously performed or currently scheduled, note date and/or result: _____

Internal use only

ID Appointment	Date: _____ /_____ /_____	Time: _____
ENT Appointment	Date: _____ /_____ /_____	Time: _____
Ophthalmology Appointment	Date: _____ /_____ /_____	Time: _____
Radiology Appointment	Date: _____ /_____ /_____	Time: _____