

VANDERBILT  UNIVERSITY

MEDICAL CENTER

Vanderbilt Asthma Sinus Allergy Program

p. 615.936.2727 f. 615.936.5767 toll free 1.866.390.0379
www.vanderbiltallergy.com

PAPERWORK

Please print the following forms and
BRING to the clinic at your first
appointment.

Do not mail or email back to us.

PLEASE USE BLACK INK ONLY
When filling out these forms.

**Before your appt, please send last 2 clinic notes from your
PCP/specialist, any pertinent lab test results and any scans/x-rays
related to your condition.**

PARKING

BE SURE TO ASK AT WHICH LOCATION YOU WILL BE SEEN:

To insure best directions from your starting location, please use GPS or MapQuest.

2611 West End Ave. between the Holiday Inn and J. Alexander's restaurant, across the street from Centennial Park. **Parking:** Park at the rear of our building in the lot that we share with the Holiday Inn. Enter the second floor of the building by crossing the covered walkway.

VASAP @ The Shoppes at Brentwood - 782 Old Hickory Blvd., Ste 203 Brentwood, TN 37027 **Parking:** The Shoppes at Brentwood parking lot

VASAP @ Franklin – 919 Murfreesboro Rd, Franklin, TN 37064

VASAP @ Lebanon – 1409 W Baddour Pkwy, Suite E, Lebanon, TN 37087

VASAP @ Gallatin – 300 Steam Plant Rd, Suite 460, Gallatin, TN 37066

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Dear Patient:

We would like to extend our welcome to you as our patient at the Vanderbilt Asthma Sinus Allergy Program (ASAP).

Our team of physicians and fellows/residents will provide you with a thorough and complete examination, resulting in an individualized treatment plan. Diagnostic tests required to complete your evaluation will be performed on site and may include pulmonary function tests, sinus CT scan, x-rays, sinus and other upper airways tests. We have a full-time educator on our staff to provide educational materials to help you fully understand your disease process.

PLEASE BE ADVISED TO NOT WEAR (OR ANYONE WITH YOU) ANY KIND OF PERFUME, AFTER SHAVE OR FRAGRANT LOTIONS.

Because of the extensiveness of your evaluation, *the initial exam may take anywhere up to 4 hours.* This limits your ability to supervise young children; therefore, we **request that young children do not accompany you.** Also, you may wish to bring a snack with you or you can visit a local restaurant nearby if you want to take a break during testing. We also provide secure lockers for your personal items during your visit, but will assume no responsibility for personal or valuable items placed in the lockers or retained by you.

We are requesting that you **complete the enclosed forms and bring these with you.** The information you provide through completion of these forms will assist us in planning your care. You will receive a telephone call from one of our staff before your visit to remind you of your appointment time. Should you have any questions of specific needs, please advise us prior to your visit. Please bring the name and address of your primary care physician so that we can keep them informed of your condition. **If your insurance requires a referral from your primary care physician, this must be obtained prior to your visit.** Please bring the necessary paperwork that day.

While it is understood that patients' schedules can change, we do require a minimum of 24 hours notice if you cannot keep your appointment. Please call us immediately if you need to reschedule.

Again, we welcome you as a new patient. We are here to serve you and desire to make your visit with us as comfortable, convenient and pleasant as possible. We welcome your suggestions for improvement and comments you may have.

We look forward to meeting you on _____ at _____ am/pm.

Sincerely,
VANDERBILT ASTHMA SINUS ALLERGY PROGRAM (ASAP)

Updated 1/25/10
VASAP Policies

VANDERBILT  UNIVERSITY

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Vanderbilt Asthma Sinus Allergy Program

2611 West End Avenue Suite 210 Nashville, TN 37203
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MEDICATIONS

NAME: _____ **DATE:** _____

PLEASE LIST BELOW ALL MEDICATIONS THAT YOU HAVE TAKEN OVER THE LAST MONTH FOR ANY CONDITION.

(PLEASE INCLUDE ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS, INCLUDING BIRTH CONTROL PILLS, INSULIN, ASPIRIN, SINUS MEDICATIONS, HORMONES, PATCHES, OINTMENTS, INJECTIONS, NASAL SPRAYS, ETC.)

NAME OF MEDICATION	STRENGTH OR DOSE	HOW MANY PER DAY/WEEK?	WHAT IF ANY SIDE EFFECTS?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

MEDICATION/DRUG ALLERGIES:

Please list below any medication/drug which you cannot take due to an allergy or a side effect from taking the drug and the reaction which occurs.

Name of Medication/Drug	Type of Reaction
1.	
2.	
3.	
4.	

Additional information:

Date: _____

To the Parents of _____ is scheduled for possible skin testing at his/her appointment on _____ at _____ am/pm.

Prick skin test may be done to help identify if your child is allergic and what he/she may be allergic to. Please follow these directions when getting ready for this test:

All antihistamines will affect the results of some of the tests and need to be STOPPED 10 DAYS before testing is done.

Below is a list of commonly prescribed and over-the-counter antihistamines. **Please continue asthma inhalers as prescribed.** Some psychiatric medicines such as antidepressants, etc. may affect testing. Please call if there are any question or concerns.

Examples of antihistamines to **STOP taking 10 days before** your visit:

Accuhist
Actifed
Advil Allergy Sinus
Allegra (Fexofenadine)
Amitriptyline (4-6 weeks)
Antivert (Meclizine)
Astelin nasal spray
Astepro
Atarax (Hydroxyzine)
Benadryl (diphenhydramine)
Brompheniramine
Chlorpheniramine
Claritin (Loratadine)
Claritin D
Clarinex
Compazine
All OTC cough/cold preparations

Deconamine
Dimetapp
Doxepin (4-6 Weeks)
Dristan
Drixoral
Extendryl
Mescolor
Naldecon
Nortriptyline
Nyquil
Patanase Nasal Spray
Pediocare
Periactin
Phenergan (Promethazine)
Sudafed Plus
Resoon
Xyzal (levocetirizine)

Robitussin
Rynatan (Azatadine)
Tavist
Triaminic
Tylenol Allergy Sinus
Tussi-12
Zyrtec (cetirizine)
Zyrtec S (cetirizine)

Eye drops:
Levostin
Optivar
Patanol / Pataday
Elestat
Other OTC eye drops

Please call the nurse at 615.936.2727, Opt 2, if you are unsure if a medication your child is taking contains antihistamines. Remember, asthma medications should be continued as usual. There are a very few other pediatric medications which may interfere with testing. Please call if unsure.

Thank you,
Donna Hummell, MD

Updated 1/25/10

New Patient Checklist

- Eat breakfast
- Wear comfortable clothes and shoes
- If this is your first visit, please plan on being at the VASAP clinic for a **minimum of 4 hours**
- Please call Central Registration (1.888.567.5255 or 616.322.2971) if you have not done so already
- Completed Patient Information form
- Completed Medication form
- Completed VASAP Patient Questionnaire form
- Bring your insurance card / information to your first appointment
- Provide us with your pharmacy name, address, phone and fax numbers
- Referral (if required)
- Arrive 30 minutes prior to your appointment – we do our best to see patients timely, however, unforeseen events may cause delays. We do try to keep on schedule as much as possible.
- Prior to visiting us in your first visit to Vanderbilt ASAP – register for *MyHealthatVanderbilt.com*. This website allows you to send emails to us regarding appointments and prescription refills. Once you have registered and visited us in the office, we can update your status so you can review your lab results. Ask the person at check in to help you with this.
- Bring reading materials or personal entertainment (iPod w/headphones, etc.)

Any questions, please do not hesitate to contact us.

Sincerely,

VANDERBILT ASTHMA SINUS ALLERGY PROGRAM

ALLERGY QUESTIONNAIRE

Patient: _____

MR#: _____

Date: _____

FAMILY HISTORY	AGE	ALLERGIC CONDITION
Mother		
Father		
Sibling		
Sibling		
Sibling		
Sibling		

ENVIRONMENTAL SURVEY

Any smokers in the home? _____

Type of residence: Single family home _____ Apartment _____ Mobile home _____

Years living in the residence; _____

Does the residence have a basement _____ crawl space _____ slab _____

List any noticed moisture, mold, or mildew problems: _____

Type of heating system: Forced air _____ Wood stove _____ Gas _____ Steam _____ Electric wall _____

Type of cooling: Central A/C _____ Window unit _____ Fans _____

Do you use a cool mist room humidifier? _____ Do you use a steam vaporizer? _____

Are there indoor plants? _____

Are there pets? _____ Types: _____

PATIENT'S BEDROOM

Does child share room? _____

Are mattress, box springs and pillows encased in dust mite protective covers? _____

Are there stuffed toys in the child's room? _____

Type of bedding: _____

Amount of wall hangings and knick-knacks: _____

Type of window coverings: _____

Type of flooring: _____

DAYCARE / SCHOOL

Type of daycare: _____

Age started daycare/school: _____

Grade in school: _____

PAST MEDICAL HISTORY

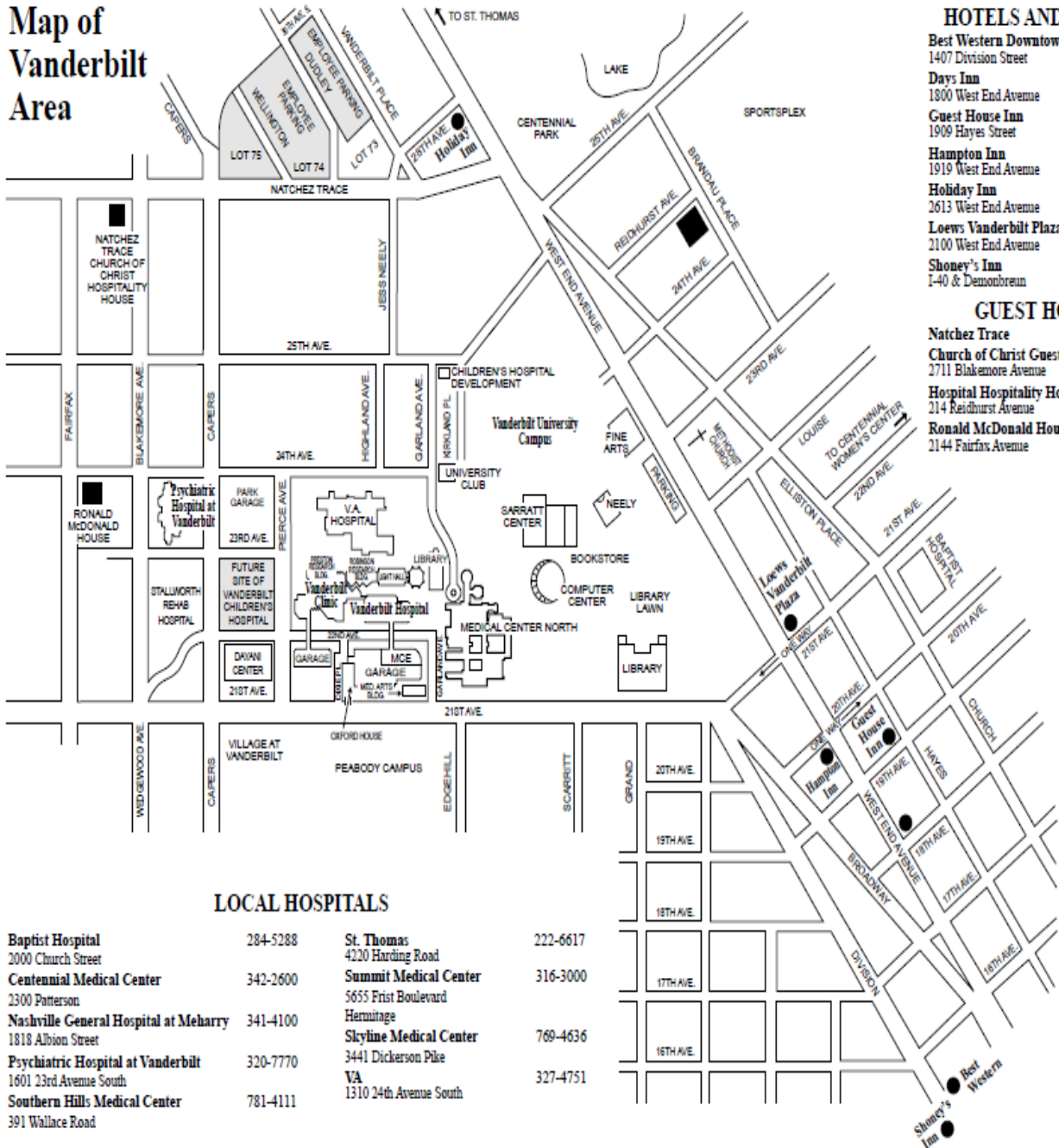
Has the child had any of the following infections and if so, how many?

- Pneumonia _____
- Ear infections _____
- Sinus infections _____
- Skin infections _____ MRSA? _____

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**Map of
 Vanderbilt
 Area**



HOTELS AND MOTELS

Best Western Downtown 1407 Division Street	242-1631
Days Inn 1800 West End Avenue	327-0922
Guest House Inn 1909 Hayes Street	329-1000
Hampton Inn 1919 West End Avenue	329-1144
Holiday Inn 2613 West End Avenue	327-4707
Loews Vanderbilt Plaza Hotel 2100 West End Avenue	320-1700
Shoney's Inn I-40 & Demonbreun	255-9977

GUEST HOUSES

Natchez Trace	
Church of Christ Guest House 2711 Blakemore Avenue	297-0387
Hospital Hospitality House 214 Reidhurst Avenue	329-0477
Ronald McDonald House 2144 Fairfax Avenue	343-4000



LOCAL HOSPITALS

Baptist Hospital 2000 Church Street	284-5288	St. Thomas 4220 Harding Road	222-6617
Centennial Medical Center 2300 Patterson	342-2600	Summit Medical Center 5655 Frist Boulevard	316-3000
Nashville General Hospital at Meharry 1818 Albion Street	341-4100	Hermitage	
Psychiatric Hospital at Vanderbilt 1601 23rd Avenue South	320-7770	Skyline Medical Center 3441 Dickerson Pike	769-4636
Southern Hills Medical Center 391 Wallace Road	781-4111	VA 1310 24th Avenue South	327-4751

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VASAP SERVICES THAT MAY BE ORDERED BY YOUR PROVIDER ON YOUR FIRST VISIT

***Please use this list when calling your insurance provider to verify benefits and coverage prior to your appointment on _____.**

Patient name: _____, _____
Last First MI

TEST	INSURANCE CODE BILLED
CT scan of the Maxillofacial Sinus (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the imaging service)	70486
Deductible: Y/N _____ Coinsurance: Y/N _____ Co-Pay: Y/N _____	Amount \$: _____ Amount %: _____ Amount \$: _____
Allergy Skin Testing (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the allergy skin testing)	95004 and /or 94024
Deductible: Y/N _____ Coinsurance: Y/N _____ Co-Pay: Y/N _____	Amount \$: _____ Amount %: _____ Amount \$: _____
Spirometry (breathing treatment for your lungs) (*ask your carrier if you have a deductible, coinsurance or co-pay that you will owe for the breathing treatments)	95010 and /or 94060
Deductible: Y/N _____ Coinsurance: Y/N _____ Co-Pay: Y/N _____	Amount \$: _____ Amount %: _____ Amount \$: _____

Does my insurance require a referral to a specialist? Y/N _____

Does my insurance require me to use a specific laboratory when blood test or other specimen collection for treatment is performed? Y/N _____

If yes, name of laboratory: _____