Gillette Children's
Specialty Healthcare

International Patient Questionnaire

Please fill out form in English

Date: ______________ **Has this patient been seen at Gillette?** ☐ Yes ☐ No

PATIENT DEMOGRAPHICS

Patient **First** Name: ____________________ Address: ____________________

Patient **Middle** Name: ____________________

Patient **Last** Name: ____________________

Date of Birth: ____________________ City ____________________

Gender: ☐ Male ☐ Female Country: ____________________

Email ____________________ Phone Number

PARENT / LEGAL GUARDIAN INFORMATION

Mother's Name: ____________________ ☐ N/A Contact Email: ____________________

Father's Name: ____________________ ☐ N/A Contact Email: ____________________

Legal Guardian: ____________________ Address: ____________________

Relationship to Patient: ____________________

Contact Email: ____________________ City ____________________

Documentation of Guardianship: ☐ Yes ☐ No ☐ N/A Country: ____________________

COMMUNICATION / SPECIAL NEEDS

Patient Verbal? ☐ Yes ☐ No Method of Communication: ____________________

Interpreter Needed? ☐ Yes ☐ No Language: ____________________

SYMPTOMS/REASON FOR REFERRAL

DIAGNOSIS:

☐ Epilepsy/Seizure Disorder ☐ Cerebral Palsy ☐ Spina Bifida ☐ Spinal Cord Injury

☐ Muscular Dystrophy ☐ Polio ☐ Brain Injury ☐ Spinal Muscular Atrophy

☐ Chromosomal Abnormalities ☐ Other: ☐ Unknown

Other Medical Conditions (in addition to reason for visit)

Is patient on a ventilator? ☐ Yes ☐ No

Has the patient ever been diagnosed with tuberculosis, MRSA, or any other communicable disease? ☐ Yes ☐ No

If yes, please specify:

PAYMENT: Do not leave blank

☐ Self ☐ Embassy ☐ MIM ☐ Sponsoring Organization ☐ Insurance

Insurance Name ____________________ Address: ____________________

Policy Holder ____________________ Group Number ____________________ ID Number ____________________

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