UT Mitochondrial Center of Excellence

Mary Kay Koenig, MD, Director
Melissa Knight, Special Projects
Grace O'Toole, LMSW Clinical Social Worker
LaKeesha Minor, RN, BSN Clinic Coordinator
Rahmat Adejumo, Research Coordinator
Alexis Loud, Administrative Assistant

Phone: 713-500-7164 ⋮ Fax: 713-500-0719 ⋮ Email: ut.mito@uth.tmc.edu ⋮ Website: www.utmito.org

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

Mailing Address – This is not where appointments are held

The UT Mitochondrial Center of Excellence
6410 Fannin Street, Ste. 732
Houston, TX 77030

Fax- 713-500-0719

Email- ut.mito@uth.tmc.edu

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

- ☐ Patient Information Form
- ☐ Mitochondrial Center of Excellence Policy Form
- ☐ Photo/Video Consent
- ☐ Email Consent
- ☐ Physician Contact Form
- ☐ Complete Physician List
- ☐ Medical Records Release Form- one for every physician/hospital from birth to present
- ☐ Medication List
- ☐ Diet Information
- ☐ Review of Systems
- ☐ Patient story- please see Mitochondrial Center of Excellence Policy Form for information

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

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

Children's Memorial Hermann Hospital

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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	

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Mitochondrial Center of Excellence Policies

Services:

Dr. Mary Kay Koenig is a pediatric and adult neurologist who specializes in neuro-metabolic and mitochondrial diseases. She is not a primary care physician and she is not a metabolic geneticist. Dr. Koenig will work with your PCP to help optimize your health care. Dr. Koenig's clinical notes will be forwarded to your PCP and/or the referring physician.

Prior to your first appointment:

Dr. Koenig asks that parents submit a **summary** of the child's life, starting with pregnancy. This should be written in a story format by the person that knows the patient's history best.

All medical records need to be received before your first appointment is scheduled. It is imperative that all records from birth to present are forwarded to aid Dr. Koenig in making appropriate recommendations for your child. Due to time constraints, Dr. Koenig will not be able to review any medical records brought to the clinic at the first visit.

You have been provided with a medical records release form. Print as many copies of this form as you need. **It is your responsibility to fill this form out with the information for all medical providers and hospitals that have been a part of your child's care. Please return these forms with the rest of your new patient packet. We will submit these to each provider. We do not accept medical records from the patient and/or their family**.

You will be responsible for returning the email and photo consent forms, along with the medication list.

Once we have received all of the medical records and necessary paperwork, we will contact you to schedule an appointment.

First appointment expectations:

Expect to spend approximately 3 hours in the Mitochondrial Clinic for your initial appointment. Dr. Koenig may order blood work and/or urine that should be completed on the day of the appointment. She may also order additional testing to be done at Children's Memorial Hermann Hospital at a later date. If necessary, we can coordinate with your PCP to have the blood work and diagnostic testing performed at a hospital near your home. You should not expect to have anything other than blood work and/or urine done at your initial appointment.

Tests and lab results policy: Our office will review only tests and labs that are ordered by Dr. Mary Kay Koenig. You will be contacted if there are any urgent results. All other results will be reviewed in person at your next scheduled appointment. For results of tests and labs ordered by other physicians, please contact that physician's office.

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Cancellation policy: The UT Mitochondrial Center adheres to a stringent cancellation policy. We work to see each new patient in a timely manner; however patients often wait 6 months or more to be seen. We understand that this is particularly hard on families and we believe that we must make the most of each new patient appointment spot. If you are unable to keep your scheduled new patient appointment, it is your responsibility to notify the clinic at least 7 days prior to your appointment. This allows us to fill your appointment spot with someone on the waiting list. If you cancel within 7 days of your appointment or if you do not show up for your appointment, we will not be able to reschedule your child in this clinic. We will take into account emergencies that are verified by your PCP.

Record reviews: If you are unable to travel to Texas or are unsure if the trip will be beneficial, Dr. Koenig is able to review medical records and comment on diagnosis and management. Because this review is time-consuming, she charges a flat rate of $500 for this review. You will need to submit payment along with all clinic paperwork and medical record releases. Once all paperwork is received, Dr. Koenig will review your records. Following the review, she will forward a written report to you and your physician summarizing her findings and recommendations. As this review does not entail a clinical visit, it does not create a doctor-patient relationship and Dr. Koenig will not be able to speak with you directly regarding her recommendations. She will be available to speak with your physician if you choose.

We look forward to working with you and your child to aid in diagnosis and/or care. Please contact us with any questions or concerns.

_____ _____

Patient Name Date of Birth

_____ _____

Parent Name Date

_____

Signature

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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 Mitochondrial Center of Excellence
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:

_____

_____

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Review of Systems

Name of person completing form: _____

Relationship to patient: _____

Mitochondrial Disease

Has the patient already been diagnosed with a mitochondrial disease? Yes No

If yes, name of doctor that made the diagnosis:_____

If yes, what type of mitochondrial disease: _____

Has the patient had any of the following:

- ☐ Muscle Biopsy Date:_____ Findings: _____
- ☐ Skin Biopsy Date:_____ Findings: _____
- ☐ Brain MRI Date:_____ Findings: _____
- ☐ Lumbar Puncture Date:_____ Findings: _____
- ☐ EEG Date:_____ Findings: _____
- ☐ Metabolic labs Date:_____ Findings:_____

Constitutional

Height _____ Weight _____

- ☐ Abnormal weight loss or gain
- ☐ Fatigue
- ☐ Muscle aches

Eyes

- ☐ Blurred vision ☐ Flashes of light ☐ Vision loss ☐ Droopy eyelids
- ☐ Double vision ☐ Floaters ☐ Date of last vision exam _____
- ☐

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Neurological

- ☐ Balance problems
- ☐ Difficulty comprehending
- ☐ Coordination problems
- ☐ Fainting spells
- ☐ Headaches
- ☐ Loss of awareness
- ☐ Loss of consciousness
- ☐ Loss of memory
- ☐ Numbness or tingling
- ☐ Autism
- ☐ Seizures
- ☐ Speech disorder
- ☐ Problems with swallowing
- ☐ Tremors or shakes
- ☐ Twitching
- ☐ Dizziness/Vertigo
- ☐ Walking problems
- ☐ Neuropathy
- ☐ Developmental Delay
- ☐ Others:

Date of last neurological exam: _____

Cardiovascular

- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Tightness
- ☐ Autonomic dysfunction
- ☐ Swelling (edema)
- ☐ Leg cramping
- ☐ High blood pressure
- ☐ Others:

Has the patient ever had the following:

- ☐ EKG Date:_____ Findings:_____
- ☐ Echocardiogram Date: _____Findings: _____
- ☐ Tilt Table Date:_____ Findings: _____

Date of last cardiac evaluation: _____

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Ear, Nose, and Throat

- ☐ Skin rashes
- ☐ Decreased hearing
- ☐ Frequent ear infections
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Insomnia
- ☐ Skin color changes
- ☐ Ringing in ears (tinnitus)
- ☐ Ear tubes
- ☐ Restless legs
- ☐ Excessive sleep
- ☐ Others:

Has the patient ever had the following:

☐ Hearing exam Date:_____ Findings:_____

☐ Sleep study Date:_____ Findings:_____

☐ Tonsillectomy Date:_____

☐ Adenoidectomy Date:_____

Endocrine

- ☐ Heat or cold intolerance
- ☐ Excessive sweating
- ☐ Change in appetite
- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Other:

Gastrointestinal

- ☐ Reflux
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Constipation
- ☐ Dysmotility
- ☐ Feeding intolerance
- ☐ Elevated liver enzymes
- ☐ Tube feeding
- ☐ Cyclic vomiting
- ☐ Pancreatitis
- ☐ Pseudo-obstruction
- ☐ Gastroparesis
- ☐ Failure to thrive
- ☐ Others:

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Has the patient ever had the following:

- ☐ Endoscopy Date:_____ Findings:_____
- ☐ Colonoscopy Date:_____ Findings:_____
- ☐ Gastric Emptying Scan Date:_____ Findings:_____
- ☐ Manometry Date:_____ Findings:_____
- ☐ Liver biopsy Date:_____ Findings:_____

Genitourinary

- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Neurogenic bladder
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Others:

Hematologic

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Others:
- ☐ Anemia
- ☐ Clotting disorder

Musculoskeletal:

- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Hypotonia
- ☐ Others:
- ☐ Back pain
- ☐ Arthritis
- ☐ Hypertonia

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Respiratory

- ☐ Asthma
- ☐ Frequent airway infections
- ☐ Pneumonia
- ☐ Required intubation
- ☐ Require oxygen
- ☐ Require CPAP/BiPAP or other
- ☐ Tracheotomy
- ☐ Others:

Hospitalizations

Please list all prior hospitalizations. If you require more space, please insert a new sheet.

Date	Place & Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries

Please list all prior surgical procedures. If you require more space, please insert a new sheet.

Date	Place, Procedure & Reason
_____	_____
_____	_____
_____	_____
_____	_____