Midwest Allergy Sinus Asthma, SC
2010 Jacobssen Drive, Normal, IL 61761
2151 West White Oaks Drive, Springfield, IL 62704
Phone: 309-452-0995 or 217-717-4404, Ext 7541
Fax: 309-862-0961 or 217-718-5284
Website: www.asthma2.com

PANS/PANDAS New Patient Screening Form

To help our providers review your referral efficiently, please complete this form before scheduling. This information allows our team to determine appropriate next steps for care.

1. PATIENT INFORMATION

Patient Full Legal Name: Date of Birth: Age:

Parent / Guardian Name (if patient is a minor):

Best Contact Phone Number:

Email Address:

2. INSURANCE INFORMATION

Primary Insurance Provider:

Policy Holder Name: Member ID:

If MASA is not in network with your insurance, do you understand you may have out-of-network costs?

□ Yes □ No □ Unsure

3. REFERRAL INFORMATION

How did you hear about MASA?

□ Referring physician
□ Online search
□ Social media
□ Friend / family
□ Other: _____

Referring Provider Name:

Referring Provider Practice / Clinic:

Provider Specialty:

Has your pediatrician or psychiatrist officially diagnosed or agreed with a possible PANS/PANDAS condition?

□ Yes □ No □ Unsure

4. BEHAVIORAL / PSYCHIATRIC CARE

Is the patient currently seeing a psychiatrist, psychologist, or counselor?

□ Yes □ No

If yes:

Provider Name:

Clinic Name:

Date last seen:

Has the patient seen any behavioral specialists in the past?

□ Yes □ No

If yes, please list:

Midwest Allergy Sinus Asthma, SC
2010 Jacobssen Drive, Normal, IL 61761
2151 West White Oaks Drive, Springfield, IL 62704
Phone: 309-452-0995 or 217-717-4404, Ext 7541
Fax: 309-962-0961 or 217-718-5284
Website: www.asthma2.com

PANS/PANDAS New Patient Screening Form

To help our providers review your referral efficiently, please complete this form before scheduling.
This information allows our team to determine appropriate next steps for care.

5. NEURODEVELOPMENTAL HISTORY

Has the patient been diagnosed with Autism Spectrum Disorder (ASD)?
□ Yes □ No

If yes:

Is the patient non-verbal or requiring high levels of support?
□ Yes □ No

Has the patient been diagnosed with ADHD?
□ Yes □ No

Has the patient been diagnosed with Tic Disorders?
□ Yes □ No

6. SYMPTOM HISTORY

Has the patient experienced sudden loss of previously developed skills, such as:

□ Handwriting
□ Speech
□ Toileting
□ Other: _____

Approximate date of first flare or symptom onset:

7. KEY SYMPTOMS

Does the patient currently experience:

Obsessive-Compulsive symptoms (OCD)?
□ Yes □ No

Severe restrictive eating?
□ Yes □ No

Sudden extreme anxiety?
□ Yes □ No

Emotional lability (rapid mood swings)?
□ Yes □ No

8. INFECTION HISTORY

Has the patient experienced recurrent infections?
□ Yes □ No

If yes, please indicate which types:

□ Strep throat
□ Sinus infections
□ Ear infections
□ Walking pneumonia / Mycoplasma
□ Other: _____

Approximate number of infections per year:

Midwest Allergy Sinus Asthma, SC
2010 Jacobssen Drive, Normal, IL 61761
2151 West White Oaks Drive, Springfield, IL 62704
Phone: 309-452-0995 or 217-717-4404, Ext 7541
Fax: 309-962-0961 or 217-718-5284
Website: www.asthma2.com

PANS/PANDAS New Patient Screening Form

To help our providers review your referral efficiently, please complete this form before scheduling.
This information allows our team to determine appropriate next steps for care.

9. IMMUNIZATION STATUS

Is the patient up to date on routine vaccinations?
□ Yes □ No □ Partially

If any vaccines were delayed or declined, please list:

10. SURGICAL HISTORY

Has the patient had any of the following procedures?

Tonsillectomy (tonsils removed)
□ Yes □ No

Adenoidectomy (adenoids removed)
□ Yes □ No

If yes, year of surgery:

11. PREVIOUS PANS/PANDAS TREATMENTS

Has the patient been treated for PANS/PANDAS by another provider?
□ Yes □ No

Has the patient received:

IVIG (Intravenous Immunoglobulin)?
□ Yes □ No

Subcutaneous IgG therapy?
□ Yes □ No

Have recent immunoglobulin labs been performed?
□ IgG
□ IgA
□ IgM
□ Not sure

If yes, please indicate where and when the labs were performed:

PATIENT / PARENT ACKNOWLEDGMENT

I understand that this form is used for screening purposes only and does not guarantee an appointment. MASA's clinical team will review the information and determine the appropriate next steps.

Signature: _____

Date: _____