

MRN:  
Patient Name:

(Patient Label)

**PEDIATRIC PULMONOLOGY  
Contact Sheet**

Dear Patient and Parent(s),  
We are collecting additional information to allow us to better communicate with you regarding future appointments, updates with our division and in the Asthma field. Please complete the information below. Thank you.

Douglas Li, MD, Sande Okelo, MD, Marlyn Woo, MD  
Division of Pediatric Pulmonology, Mattel Children's Hospital

**PLEASE PROVIDE US WITH YOUR CURRENT INFORMATION**

What is your phone number?  N/A

Phone Number: (    )    -

May we leave messages on your voicemail?  Yes  No

If you have a cell phone, may we contact you by cell phone, please write it below.  N/A

Cell Number: (    )    -

May we leave messages on your voicemail?  Yes  No

Would you like to be contacted by text?  Yes  No

What is your cell carrier?  ATT&T  Verizon  Sprint  T-Mobile  Other : \_\_\_\_\_

Reminder: Charges may apply based on your cell phone plan.

Would you like to be contacted by email?  Yes  No

Email Address: \_\_\_\_\_

If we have difficulty contacting you, can you please provide the name and phone number of one person who can reach you?

First Name: 

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Last Name: 

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Phone Number: (    )    -

Relationship:  Mother  Father  Friend  Neighbor  Family Member