Bravo Health Marfa
105 E Oak St
Marfa, TX 79843
P: (432) 729-3000 | F:(432) 729-3001

Referral Form

Referring to: Dr. Jane Doe
Referred from: DANIELLE OLSZESKI, PA

Patient Information:

Patient: 1xxxtest 1xxxtest **DOB:** 01/01/2023 **Sex:** Male
Patient Address: 123 Main St Houston TX 77012 **Patient Phone:** (555)-555-5555
Patient Diagnosis:

Reason for Referral:
evaluate and treat for pt has a cough x 1 month with no improvement. (R05.1)

Additional Referral Notes:

Insurance Information:
Trio Plan00000
Authorization #:
# of Visits:
Expiration Date:

MEMORIAL HERMANN
OnSite Clinic
IN ASSOCIATION WITH Hamilton Health Box

HAMILTON HEALTHBOX

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

Patient Demographics

Patient Name:	1xxxtest 1xxxtest		
Date of Birth:	01/01/2023		
Gender:	Male		
Preferred Language:	English	**Bill Type:**	SELF PAY (PATIENT)

Care Team

Rendering Provider: DANIELLE OLSZESKI, PA

Date and Location of Visit

Date of Service:	12/22/2025		
Chart Number:	HHB4A16	**Appointment:**	12/22/2025 09:30 AM CST
Chart Classes:	Follow Up Visit	**Appt. Reason:**	FOLLOW UP
Location:	HHBTBM	**Notes:**	cough x3 days follow up

Medication Summary

Drug Allergies
sulfabenzamide (sulfabenzamide) Unknown (Active)
Peanut (Peanut) urticaria (hives), Eye swelling (Active)
cat dander (cat dander) urticaria (hives), Eye swelling (Active)

Current Medications
omeprazole (omeprazole) capsule,delayed release(DR/EC) 20 mg Take 20 mg by mouth once a day
ibuprofen (ibuprofen) capsule 200 mg 1 capsule by mouth three times a day as directed
amoxicillin (amoxicillin) capsule 500 mg 1 capsule by mouth twice a day , 20 capsules

Medication Reconciliation:
Relevant and performed

Chief Complaint / Assistant Note

Pt 1xxxtest, a 2 y.o.(35 m.o.)Male, presents with .cough

Subjective

HPI

What brings you in today?
→ "What&#39s going on?" or "What are you being seen for today?"

When did it start?
→ Days, weeks, etc.

Where is it located?
→ Be specific: "left knee," "lower back," etc.

What does it feel like?
→ Sharp, dull, pressure, itchy, etc.

Has it gotten better, worse, or stayed the same?

Any other symptoms?
→ Fever, nausea, cough, swelling, etc.

Have you done anything to treat it so far?
→ Medications, ice/heat, rest, ER/urgent care, home remedies

Medical History- Pediatrics
Birth History
Hospital: Doctor: Birth weight: Length:
Number of weeks gestation:
Pregnancy: ☑ Uncomplicated. ☐ Complications
Other

Delivery: ☐Vaginal ☐C-Section

Neonatal
☐Uncomplicated ☐Jaundice ☐ Other
Feedings
☐Breast, Weaned At: ☐Formula, Type: , Number of months
☐Food Intolerance ☐Solids Started. ☐Colic
Appetite Now Vitamins

Development (Age patient stared the following activities):
Smiled Rolled Over Sat w/o Support
Walked First Words Potty Trained
Present Grade In School Preent performance in school

Past Medical History: ☐**None**

☐ADHD	☐Croup	☐Recurrent Respiratory Infection		
☑Allergies	☑ Ear Infection	☐Rubella		
☐Amputation	☑Eczema	☐Scarlet Fever		
☐Anemia	☐Fifths Disease	☐Seizures		
☑Asthma	☐Headaches	☑Sinus Infection		
☐Autoimmune Disorder(s)	☐Heart Murmur	☑Teeth/dental issues		
☐Autoimmune Disorder(s)	☐Joint Pain	☐Tonsilitis		
☐Bed Wetting	☐Heart Condition	☐Urinary Tract Infection		
☐Blood Disorder(s)	☐Measles	☐Vision Issues		
☐Bronchitis	☐ Mumps	☐		
☐Chicken Pox	☐Painful Urination	☐		
☐Constipation	☐Pneumonia	☐		

FAMILY MEDICAL HISTORY ☑ family history unknown

Mother	☐Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Father	☐Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Siblings	☐Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Family (Other)	☐Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)

Social History:
Do you live with a smoker? ☐ Yes ☑ No
Are you a smoker? ☐Yes ☑No ☑N/A Have you ever been a smoker? ☐ Yes ☑ No ☐ N/A
If yes, Age Started Smoking Age Stopped PPD
Are you an E-Cigarette User ☐Yes ☑No' Do you use smokeless tobacco? ☐Yes ☑No
Sexually Active no

SURGICAL HISTORY ☑ NOT APPLICABLE

What Kind?	Where was it done?	When?

Specialists: ☑None

Specialty	Frequency	Last Visit	Next Visit	Comment/Reason

Hospitalizations, Accidents, Injuries or Other Medical Problems: ☑None

Why?	Where?	When?

Gynecology History- Females 10+ years only:
☑n/a
Date of last menstrual period: Currently Pregnant? . Breastfeeding
G: P: M: A:
Method of Contraceptive:

Smoking Status

Status:	Never smoker
Effective Date:	12/10/2025
Snomed code:	266919005

Problem History

C.S.	Code	Description	Status	Diagnosed	Edu	Cog	Func	Diagnosed By	Resolved By
ICD10	R06.2	Wheezing	ACTIVE	12/07/2025 09:37 PM CST	Yes	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	J45.20	Mild intermittent asthma, uncomplicated	ACTIVE	12/07/2025 09:37 PM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	J00	Acute nasopharyngitis [common cold]	ACTIVE	12/05/2025 12:00 AM CST	No	No	No	RACHEL MENGES, FNP-BC	N/A
ICD10	M25.561	Pain in right knee	ACTIVE	12/04/2025 12:00 AM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	R05.1	Acute cough	ACTIVE	11/24/2025 08:51 AM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	R05.3	Chronic cough	ACTIVE	11/24/2025 12:00 AM CST	Yes	No	No	DANIELLE OLSZESKI	N/A
ICD10	M54.59	Other low back pain	ACTIVE	11/24/2025 12:00 AM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	J30.2	Other seasonal allergic rhinitis	ACTIVE	11/20/2025 04:31 PM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	Z00.01	Encounter for general adult medical exam w abnormal findings	ACTIVE	11/20/2025 04:02 PM CST	Yes	No	No	DANIELLE OLSZESKI	N/A

Health Concerns

Health Concern	Linked Problems	Status	Start	End	Categories
asthma		ACTIVE			Functional

ROS

REVIEW OF SYSTEMS		
SYSTEMS	**WNL**	**ABNORMAL**
GENERAL	☐	☐WEIGHT CHANGE ☐FATIGUE ☐FEVER ☐CHILLS ☐NIGHT SWEATS ☐DECREASED ENERGY LEVEL ☐RECENT ILLNESS ☐WEAKNESS ☐INSOMNIA ☐SWEATING ☐NOCTURNAL COUGH
SKIN	☐	☐DELAYED HEALING ☐RASH ☐BRUISING ☐BLEEDING ☐SKIN DISCOLORATION ☐CHANGE IN SKIN LESION/MOLE ☐LUMP ☐BUMP ☐SKIN LESION ☐SORE ☐INSECT BITE
HEAD	☐	☐ HEADACHES ☐ITCHY SCALP ☐ RECENT HEADINJURY ☐ CONCUSSION
EYES	☐	☐BLURRED VISION ☐CHANGE IN VISION ☐DISCHARGE ☐EYE PAIN ☐PHOTOPHOBIA ☐EYE REDNESS
EARS	☐	☐EAR PAIN ☐HEARING LOSS ☐RINGING IN EAR ☐DISCHARGE ☐HEARING AID
NOSE/MOUTH/THROAT	☐	☐SINUS CONGESTION ☐DYSPHAGIA ☐NOSE BLEED ☐NASAL DISCHARGE ☐DENTAL PAIN ☐HOARSENESS ☐SORE THROAT
BREAST ☐N/A	☐	☐LUMPS ☐BUMPS ☐CHANGES
HEME/LYMPH/ENDO	☐	☐HIV ☐BRUISING ☐HX OF BLOOD TRANSFUSION ☐NIGHT SWEATS ☐SWOLLEN GLANDS ☐INCREASE THIRST ☐INCREASE HUNGER ☐COLD INTOLERANCE ☐HEAT INTOLERANCE ☐ABNORMAL BLEEDING
CARDIOVASCULAR	☐	☐CHEST PAIN ☐PALPITATIONS ☐PND ☐ORTHOPNEA ☐EDEMA ☐SWEATING WITH FEEDING ☐EXERCISE INTOLERANCE
RESPIRATORY	☐	☐COUGH ☐WHEEZING ☐HEMOPTYSIS ☐DYSPNEA ☐PNEUMONIA HX ☐TB ☐ASTHMA HX ☐PRODUCTIVE SPUTUM ☐HOME OXYGEN @LPM.
GASTROINTESTINAL	☐	☐NAUSEA ☐VOMITING ☐DIARRHEA ☐CONSTIPATION ☐HEPATITIS ☐HEMORRHOIDS ☐EATING DISORDER ☐ULCER ☐BLACK TARRY STOOL ☐ABDOMINAL PAIN ☐BLOOD IN STOOL ☐GERD ☐HEARTBURN
GENITOURINARY/NEPHROLOGY	☐	☐URGENCY ☐FREQUENCY ☐BURNING ☐DYSURIA ☐CHANGE IN COLOR OF URINE ☐INCONTINENCE ☐DISCHARGE ☐BLOOD IN URINE ☐PAINFUL/SWOLLEN GENITAL AREA
GYNECOLOGICAL ☐N/A **LNMP**	☐	
MUSCULOSKELETAL	☐	☐BACK PAIN ☐JOINT SWELLING ☐STIFFNESS ☐JOINT PAIN ☐FRACTURE HX ☐OSTEOPOROSIS ☐MUSCLE WEAKNESS ☐MYALGIA ☐FREQUENT FALLS ☐NECK PAIN ☐BACK PAIN
NEUROLOGICAL	☐	☐SYNCOPE ☐SEIZURES ☐TRANSIENT PARALYSIS ☐WEAKNESS ☐PARESTHESIA ☐BLACK OUT SPELLS ☐SENSORY CHANGE ☐TINGLING☐DIZZINESS ☐SPEECH CHANGE ☐HEADACHE ☐TREMORS ☐DIFFICULTY/TROUBLE SWALLOWING
PSYCHIATRIC	☐	☐DEPRESSION ☐ANXIETY ☐NERVOUS ☐SLEEPING DIFFICULTY ☐SUBSTANCE ABUSE ☐SUICIDAL IDEATIONS/ATTEMPTS ☐PREVIOUS DX ☐INSOMNIA ☐HALLUCINATIONS ☐DISTURBED SLEEP
ENDOCRINE	☐	☐INCREASE THIRST ☐INCREASE URINATION ☐HIGH BLOOD SUGAR ☐LOW BLOOD SUGAR
ADDITIONAL COMMENTS :		

PHQ-2

Little interest or pleasure in doing things in last 2 weeks	Select...
Feeling down, depressed, or hopeless in last 2 weeks	Select...
Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	0

Objective

Objective Notes

Assessment

Assessment Notes

Procedure

Procedure Notes

Result Values

C.S.	Code	Description	Value	Range	Flags	Reported	Status
CPT	82950	GLUCOSE TEST	100mg/dL		N	12/22/2025 11:18 AM CST	Final

Plan

Plan Notes

Patient Referred Out and Summary of Care Provided: No
Clinical Summary Provided: No

Recalls

Provider	Location	Reason	Recall Date
DANIELLE OLSZESKI, PA	HHBTBM	1 MONTH FOLLOW UP	12/30/2025
DANIELLE OLSZESKI, PA	HHBTBM	1 WEEK FOLLOW UP	12/29/2025

Additional SOAP Comments

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

Note generated by Azalea EHR - www.AzaleaHealth.com

*Please make the necessary corrections below

Name: 1XXXTEST, 1XXXTEST	HAMILTON HEALTH BOX CENTRAL	Phone: (832) 841-4269
PID: HHB4	2450 HOLCOMBE BLVD STE 2200, SUITE 2200	Fax: (832) 376-7445
MRN:	HOUSTON, TX 77021	Hours: 8:00 am - 5:00 pm

X-Ray#:
Gender: MALE
DOB: 01/01/2023 (3 y.o.(36 m.o.))
SSN:
Email:
Pri. Phone: (555)555-5555
Work Phone:
Cell Phone:
Address: 123 MAIN ST
HOUSTON, TX 77012

Emergency Name: XXXTEST XXXTEST
Emergency#: (555)555-5555
Occupation:
Employment Status:
Employer Name:
Employer Address:

*** Please notify staff of any changes below ***

Medication Updates: Yes / No
Allergy Updates: Yes / No
Primary Physician: _____

Guarantor Name: DAD, MOM
Patient's Relationship to Guarantor: DEPENDANT
Address: 123 MAIN ST
HOUSTON, TX 77021

DOB: 01/01/1990
SSN: XXX-XX-
Pri. Phone: (555)555-5555
Work Phone: ()-
Employer:

Patient Insurances

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
Name: Trio Plan Address: 11421 TODD ST HOUSTON, TX 77055 Policy #: 00000 Group #: Copay #: Patient-Relationship: DEPENDANT Insured Name: dad, mom Insured DOB: 01/01/1990 Insured SSN: Insured Gender:	XXX-XX-	XXX-XX-

Update of Information - Please update all fields inconsistant with our records above

Patient	Guarantor	Additional Notes
Pri. Phone: ( ) -	( ) -	
Work Phone: ( ) -	( ) -	
Cell Phone: ( ) -	( ) -	
Address:		
Employer:		
Other:		

By signing below, I acknowledge that the above demographic information is correct and that I have made any corrections or changes as appropriate. I understand that I may be liable for charges that result from any inaccurate information provided.

Signature: _____ Date: _____