Located at: The Joseph M. Sanzari Children’s Hospital  
Don IMUS – WFAN Center for Tomorrow’s Children  
Hackensack, NJ 07601  
Fax: 201-996-9815

Parking Garage: Corner of Atlantic & Second Street  
FOR GPS – PUT ADDRESS IN as: 60 SECOND STREET  
Please DO NOT put 30 Prospect Avenue into a GPS system as you will go to the medical center’s main garage & get lost

Doctor’s Office: 3rd Floor – Room 360 – Bader Institute
Rheumatology: Dr. Yukiko Kimura, Dr. Kathleen Haines, Dr. Suzanne Li,  
& Immunology Dr. Jennifer Weiss, Dr. Ginger Janow, Doreen Tabussi, APN, CPN  
Lynsey M. Bello, RN, Vivian Kotora, RN
Infectious Diseases: Dr. Julia Piwoz, Dr. Kevin Slavin, Dr. Aryeh Baer

Please remember to bring these things to your appointment: Your identification (License or other ID), insurance card, referral for the visit, if needed, request for consult form, co-payment or fees due & any pertinent labs or radiology reports.

Travel patients must bring/fax an immunization record & itinerary for their trip.

Directly across the street from 60Second Street, there is a sign that says “Pediatric Center Parking” just outside of our parking garage. The parking garage is under our building, and is not visible from the street. Once you pull-up to the gate at the garage, there is a sign that says “Press to Operate”: press the red button. This is an intercom system that a security guard should answer; they can see you on camera, and will open the gate without answering, but you must push the red button. If the security guard answers, tell them which doctor you are here to see & they will open the gate for you. Parking is free in this garage.

After parking, enter the elevators & take them to the ground floor. After exiting the elevator, you will be in the IMUS Center lobby. Turn left & enter the next set of elevators. Take the elevators to the 3rd floor.

Please Note: On the 3rd floor…Please sign-in at one of the Patient Check-in kiosks to notify staff that you are present, and then have a seat. One of the registrars will call you when they are ready to complete the registration process. Once they have registered you, please come to our office: When looking at the registration desk, make a right through the two wooden doors & you will be in our waiting room.

If your child is scheduled to see a physician for an evening appointment (4:30 or later), please come directly to our office. Exit the elevators on the 3rd floor and make a left-hand turn. Go through the wooden door, and down the hall to your second wooden door; once you enter, you will be in our waiting room.
Please follow the directions above to help expedite your visit.

Driving directions to our office; we look forward to seeing you

FROM GEORGE WASHINGTON BRIDGE AND EAST
Follow Route 80 West, staying in local lanes, to Exit 64B. Turn right at light onto Polifly Road. Travel North on Polifly Road. At second light, turn left onto Essex Street. Make first Right onto Second Street. Just before the Stop sign, make left into our garage

FROM PATERSON AREA AND WEST
Follow Route 80 East, staying in local lanes to Exit 63. Turn Left off exit ramp and turn right at light onto Essex Street. Go through 6th traffic light (Prospect Avenue) and after going through the light, you will make a Left onto Second Street. Just before the Stop sign, make left into our garage

FROM SOUTHERN NEW JERSEY ON THE NJ TURNPIKE
Follow Route 95-NJ Turnpike North to the junction of Route 80. Take 80 West and stay in lanes for “Local Exits” to Exit 64B for Hasbrouck Heights and Newark. Turn right at light onto Polifly Road. Travel North on Polifly Road. At second light, turn left onto Essex Street. Make 1st right onto Second Street. Just before the Stop sign, make left into our garage

FROM NORTHERN NEW JERSEY ON ROUTE 17
Follow Route 17 South to Essex Street exit. Turn left onto Essex Street. Go through 6th traffic light (Prospect Avenue) and after going through the light, you will make a Left onto Second Street. Just before the Stop sign, make left into our garage

FROM SOUTHERN NEW JERSEY ON ROUTE 17
Follow Route 17 North to Essex Street exit. Turn right onto Essex Street. Go through 6th traffic light (Prospect Avenue) and after going through the light, you will make a Left onto Second Street. Just before the Stop sign, make left into our garage

FROM THE LINCOLN TUNNEL
Take Route 3 West to Route 17 North to Essex Street exit. Turn right onto Essex Street. Go through 6th traffic light (Prospect Avenue) and after going through the light, you will make a Left onto Second Street. Just before the Stop sign, make left into our garage

FROM THE GARDEN STATE PARKWAY (EXIT 159, ROUTE 80)
From Garden State Parkway, either north or south, take Route 80 East. Follow directions above for Paterson and West.
**Pediatric Infectious Diseases Patient Questionnaire**

Please provide the following information about your child:

Patient first name ___________________________ Middle ___________________________ Last ___________________________

Home address_________________________________________ City______________________ State______ Zip_______________

Home phone (______) ______________________ Mobile (______) ______________________ Other (______) ______________________

Birth Date _____/_____/_______ Age__________ Weight__________ Sex M F

Emergency contact_____________________________________ Phone (______)____________________ Relation_____________________

Referring Physician ______________________________________ Phone (______)____________________

Address_________________________________________ City______________________ State______ Zip_______________

Primary Physician ______________________________________ Phone (______)____________________

Address_________________________________________ City______________________ State______ Zip_______________

**Parent Information**

Parent/Guardian name #1__________________________________ Birth Date _____/_____/_______

Occupation_________________________ Employer_________________________ Work phone (______)____________________

Parent/Guardian name #2__________________________________ Birth Date _____/_____/_______

Occupation_________________________ Employer_________________________ Work phone (______)____________________

Does the patient have any allergies to medications? N Y

If yes, please list the medications and the reaction that occurred for each.

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

Does the patient have pain? N Y If yes, for how long?___________ Where is it?____________

What helps it?______________________________________ What makes it worse?_________________________

Please list all medicine the patient takes, including creams, ointments, over-the-counter medications and dietary supplements

____________________________________________________________________________________________________________

MD Signature:_______________________________________________________________ Date: ___________________________

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Briefly state the reason for today’s visit:_________________________________________________________________________

Please answer these questions regarding the current medical concern. Does the patient have any of the following:

Fever higher than 100°F? N Y If yes, for how long?_______________________________________________

Night sweats? N Y If yes, for how long?_______________________________________________

Fatigue interfering with activity? N Y If yes, for how long?_______________________________________________

Weight loss due to illness? N Y If yes, how much?_______________________________________________

Runny nose or congestion? N Y If yes, please describe_______________________________________________

Sore throat? N Y If yes, for how long?_______________________________________________

Swollen glands? N Y If yes, please describe_______________________________________________

Cough? N Y If yes, please describe_______________________________________________

Chest pain? N Y If yes, please describe_______________________________________________

Abdominal pain? N Y If yes, please describe_______________________________________________

Nausea or vomiting N Y If yes, for how long?_______________________________________________

Diarrhea? N Y If yes, for how long?_______________________________________________

Blood in the stool? N Y If yes, for how long?_______________________________________________

Urinary problems? N Y If yes, please describe_______________________________________________

Headaches? N Y If yes, please describe_______________________________________________

Vision problems? N Y If yes, please describe_______________________________________________

Joint problems (swelling, pain)? N Y If yes, please describe_______________________________________________

Muscle pain or weakness? N Y If yes, please describe_______________________________________________

Rash? N Y If yes, please describe_______________________________________________

Does anyone at home smoke? N Y If yes, please state who and where_____________________________________

Please list all medical problems the patient has, such as allergies, asthma, diabetes, rheumatologic disease, kidney disease, etc.
____________________________________________________________________________________________________________

Has the patient ever been in the hospital overnight? N Y If yes, please list the medical problem and when it occurred
____________________________________________________________________________________________________________

MD Signature:_______________________________________________________________ Date: ___________________________

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