FARMINGTON SURGICAL CENTER OPENS

Connecticut Children’s new, state-of-the-art Ambulatory Surgical Center in Farmington is up and running, making it faster and easier for patients and families to access the Medical Center’s surgical services.

The 18,000 sq. ft. facility, located at 505 Farmington Ave., is readily accessible from Interstate 84. It features the most advanced equipment and infrastructure, as well as a soothing, child-centered environment and amenities such as free Wi-Fi, a refreshment area, TV, newspapers and a comfortable family waiting area. “Our goal is to have the family’s experience be as stress-free and positive as possible,” says Elizabeth Crouch, RN, MSN, director of perioperative services.

The new facility will help reduce the time patients have to wait to schedule a surgery and should reduce wait time on the day of the surgery. The center has two operating rooms—with the potential of expanding to four in the future—five preop bays and 10 postop bays.

It’s expected that approximately 2,000 surgeries will be performed at the center in its first year. A variety of cases will be scheduled, including urology, otolaryngology, sports medicine, orthopaedic and hand surgeries. The center serves patients ages 6 months to 21 years and operates weekdays from 6 a.m. to 6 p.m.

ACCESS CO-MANAGEMENT PLANS VIA WEBSITE

Referring providers interested in accessing Connecticut Children's Co-Management Plans can now do so from the Connecticut Children’s website (www.connecticutchildrens.org). Just click “For Health Care Professionals,” then “Connecticut Children’s: Leaders in Advanced Solutions for Pediatric Co-Management (CLASP.com).”

Once a provider has completed the online Continuing Medical Education workshop for a particular condition, she or he will receive an email with a username and password and instructions for logging onto the website.

This new, automated system allows the Medical Center to track overall utilization.

As plans are updated or as new plans are made available, Connecticut Children’s can also easily communicate this information to providers.

Co-Management Plans are available for:
- Concussion
- Obesity co-morbidities
- Fibromyalgia and chronic fatigue syndrome
- Lyme disease
- Migraines
- Pediatric voiding dysfunction

For questions or assistance in accessing the tools, please contact Research Associate Erin Cornell, MPH, at 860.837.5756.
More Than a Rash

Jesse Sturm, MD, MPH, prepared this issue’s case. Dr. Sturm is a pediatric emergency medicine specialist at Connecticut Children’s and assistant professor of pediatrics at the University of Connecticut School of Medicine.

PRESENTATION
A 25-month-old male was referred to Connecticut Children’s Emergency Department by an outside ED for evaluation of an apparent period of altered metal status. He had been recently treated with cefdinir for an upper respiratory infection and presented that morning with onset of a pruritic rash. He was started on a course of oral steroids and discharged but returned later due to worsening of the rash and several episodes of “poor coordination”; tripping while walking, frequently falling to the floor and then getting up and running around normally. While en route to the hospital, he had an episode of being limp and unresponsive for approximately two minutes.

Upon arrival at the outside hospital, the patient appeared cyanotic with poor respiratory effort. He was given bag mask ventilation for approximately two minutes, after which good effort returned. The patient remained altered and lethargic but with stable vital signs. No toxic-clonic seizure activity was noted; there was no fever present, and the remainder of vital signs were reported to be normal. At this point, the outside ED physician called to transfer the child to Connecticut Children’s ED with a differential diagnosis including seizure, syncope, sepsis or possibly accidental ingestion.

On arrival at Connecticut Children’s, the child was noted to be fussy and crying, yet consolable by his family. Respiratory, cardiac and abdominal exams were normal, though limited by his crying. His skin exam was notable for blanching macular lesions located diffusely on the axilla, trunk, abdomen and extremities. These lesions were not petechial or purpuric. Outside lab results only demonstrated a normal CBC without left shift.

DISCUSSION
Hench-Schonlein purpura (HSP) is primarily a childhood disease that occurs between the ages of 3 and 15 years. About half of the cases of HSP are preceded by an upper respiratory infection, especially those caused by streptococcus. Other infectious agents, vaccinations and insect bites also have been implicated as possible triggers for HSP. The classic tetrad of HSP includes palpable purpura, arthritis/arthralgia, abdominal pain and renal involvement. The rash typically appears in crops of erythematous wheals, symmetrically distributed, and located primarily in gravity- or pressure-dependent areas such as the lower extremities. The buttocks are often involved in toddlers, and the face, trunk and upper extremities in non-ambulatory children. Joint symptoms are the second most common manifestation, occurring in three-quarters of the patients. Colicky abdominal pain occurs in about half of patients and gastrointestinal bleeding in approximately 20 to 30 percent of patients. The frequency of renal involvement ranges from 21 to 54 percent in various studies, most commonly presenting as hematuria. Intussusception is the most common gastrointestinal complication of HSP. Edema and hemorrhage can act as a pathological lead-point, contributing to its development. Intussusception is limited to the small bowel in about 60 percent of cases, in contrast to idiopathic intussusception, which is usually ileocolic. Intussusception in HSP has an overall incidence of about 3.5 percent. Children demonstrating severe abdominal pain or requiring hospitalization are presumably at greater risk. In patients with HSP, ultrasound should be the initial screening test in cases of suspected intussusception.

Although contrast enemas are the standard procedure in other clinical settings to diagnose intussusception, they cannot detect ileoileal intussusception typically seen in HSP. As seen in our case, profound lethargy and altered mental status are occasionally the initial presenting signs of intussusception, without pain, rectal bleeding or other symptoms that suggest an intra-abdominal process. This clinical presentation primarily occurs in infants and is often confused with sepsis. Thus, intussusception should be considered in the evaluation of otherwise unexplained lethargy or altered consciousness, especially in infants.
Performance-Improvement Initiative Launched

Connecticut Children’s is collaborating with consulting group Huron Healthcare on a project aimed at improving the performance of the Medical Center and the Specialty Group. The year-long initiative, called Managing Value & Performance, or MVP, will focus on quality and safety, revenue, expenses, processes, systems, work flow, staffing and management.

The Medical Center chose to embark on MVP after strategic planning and ongoing assessments of the local and health care environments showed that major changes taking place are likely to have a significant effect on the hospital. With the environment changing, the hospital needs to make changes, as well, in order to fulfill its responsibility to provide the highest-quality, safest care in the most efficient and effective way possible.

In announcing the initiative, Connecticut Children’s CEO Marty Gavin said: “This is not about revenue and expense. It’s about vision, mission and culture. It’s about fulfilling our responsibilities to the children of Connecticut.”

NEW REFERRAL GUIDELINES AVAILABLE

Connecticut Children’s has posted four new Referral Guidelines online, bringing the total number of guidelines now available to 24. Four to five additional guidelines are expected over the course of 2014. Here is a list of the newly added guidelines:

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>PRIMARY AUTHOR OF REFERRAL GUIDELINE</th>
<th>CONDITION/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>Felice Heller, MD</td>
<td>Heart Murmur</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Christopher Grindle, MD</td>
<td>Otitis Media</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Mark Lee, MD</td>
<td>Idiopathic Scoliosis</td>
</tr>
<tr>
<td>Pain &amp; Palliative Medicine</td>
<td>Mick Connors, MD</td>
<td>Sedation Services</td>
</tr>
</tbody>
</table>

Special thanks to the primary care providers whose voluntary review of the guidelines contributed significantly to their quality and utility:

Gerald Calnen, MD, Enfield • Meredith Brown, PA-C, and Dianne Powers, APRN, Connecticut Children’s Medical Center Primary Care Center, Hartford • Jennifer L. Schwab, MD, Rocky Hill

Comments, questions or suggestions for new Referral Guidelines are always welcome. Please contact Research Associate Erin Cornell, MPH, at 860.837.5756.

Lunch & Learn Talks

Many of the pediatric specialists at Connecticut Children's are available to meet with your practice over lunch to discuss clinical topics, case reviews, diagnostic dilemmas and new advances. We’ll provide lunch for physicians and advanced practice clinicians. These are informal, non-CME discussions.

For more information, email Dennis Crean, RN, at dcrean@connecticutchildrens.org.

GOT DECAL?

Would you like the Connecticut Children’s five-color decal to display in the window at your practice’s registration desk? We’d be glad to send it to you. Simply email your request to pedipl@connecticutchildrens.org, along with your mailing address and the name of the person who should receive it.
**FEATURED SUBSPECIALIST**

**CARING FOR ADULTS WITH CONGENITAL HEART DISEASE**

Shailendra Upadhyay, MD, who joined Connecticut Children's Division of Cardiology this past fall, has quite a distinction: He is one of fewer than 100 fully trained adult congenital cardiologists nationwide and one of only two in Connecticut. Adult congenital cardiologists such as Dr. Upadhyay have special expertise in caring for adults with congenital heart disease. His is a field that has emerged as more and more children with congenital heart defects live to become adults.

While improved diagnostic modalities and advances in surgical and postoperative care over the last 40 years have led to more children surviving complex congenital heart abnormalities, Dr. Upadhyay says, “We have been facing challenges in caring for these children when they become adults. Most of the people who can care for these children in the best way are pediatric cardiologists, but they are not trained to care for adults. And adult cardiologists get almost no training in caring for people with congenital heart disease.”

The situation has led certain institutions to create fellowship programs to prepare physicians to address the unique needs of this population. Dr. Upadhyay completed a fellowship in adult congenital heart disease and pulmonary hypertension at Harvard Medical School’s Brigham and Women’s Hospital and Boston Children’s Hospital.

The number of people needing the care of adult congenital cardiologists is growing. According to Dr. Upadhyay, there are now over 1 million adults with congenital heart disease in the U.S. alone—more than the number of children with the conditions.

Arrhythmia is among the most common issues faced by adults with congenital heart disorders. Dr. Upadhyay has advanced training in pediatric cardiovascular electrophysiology, so he can determine if a patient needs a pacemaker for slow heart rates, a catheter ablation or a defibrillator for fast heart rates or tachyarrhythmia, and he performs these procedures when needed. He is Connecticut Children’s only full-time pediatric electrophysiologist. He also manages and treats pulmonary hypertension, another common problem in the adult congenital heart disease population.

Adult patients with congenital heart defects have non-conventional hemodynamic issues, and assistance from an adult congenital cardiologist must be sought to facilitate their care for even simple interventions such as a gall bladder surgery, orthopaedic surgery or other non-cardiac procedures. Women with congenital heart defects who become pregnant also have special medical considerations, and their care should involve a multidisciplinary approach, in addition to seeking help from an adult congenital cardiologist.

Dr. Upadhyay stresses that caring for adults with congenital heart disorders requires a team approach. That is why he is working to create a multidisciplinary Connecticut Adult Congenital Heart Service. The CTACH service will include adult congenital cardiologists, specialists in cardiac imaging, dedicated congenital heart surgeons, an electrophysiologist, pulmonary hypertension experts, interventional cardiologists, and heart failure and transplant specialists.

The plan is for the service to be based at Connecticut Children’s, but serve other Connecticut hospitals as well.

Dr. Upadhyay foresees a day when adult hospitals will have the expertise to care for these patients, but, he says, “At this time, a children’s hospital serves these patients best.”

**LOVE THOSE SLIPPERY SLOPES!**

More than two dozen children with special needs will have fun skiing the slopes of Mount Southington this winter, thanks to a remarkable program called Skiers Unlimited. Connecticut Children’s Community Relations Manager Stephen Balcanoff and Dennis Tyburski of the Center for Motion Analysis have spearheaded the program for more than 30 years. “The program goes back to Newington Children’s Hospital days, and we continued it when we became Connecticut Children’s,” Mr. Balcanoff says. “We’ve seen a lot of great things happen with kids and families and had many wonderful volunteers.”

Skiers Unlimited gives children the opportunity to participate in an outdoor activity with other children, learn a new skill, gain confidence and feel something that may be totally new to them. “Many don’t feel motion any other way,” says Mr. Balcanoff. “On skis, once they can keep their balance, gravity does the work, and they experience motion like they never have before.”

The program is made possible by a group of 50 to 60 loyal volunteers, many of them occupational and physical therapy students at Quinnipiac University and other schools. Some volunteers have stayed with the program for years.

Sports equipment retailer Alpine Haus, in Wethersfield, is a partner. Its staff fits the children with equipment and regularly inspects all items. Mount Southington makes its facility available, and volunteers and children ski there every Friday in January and February, from 1 to 3 p.m.

Children are outfitted with whatever adaptive equipment is needed to enable them to ski. A common one is a “snow slider,” which offers the stability and support of a walker, but with skis mounted on the bottom. Special devices are often used to connect the tips of skis, so they can’t cross or spread apart. Volunteers use tethers to enable the children to ski safely. “Sometimes there are three volunteers skiing with one child and all the adaptive equipment,” Mr. Balcanoff says.

At least one parent has told Mr. Balcanoff that seeing her child ski was “life-changing.” A father related how his son, who has cerebral palsy, had urged him to come see him ski, saying he was “really good at it.” The father was moved, because, as Mr. Balcanoff says, “It was the first time the child had ever said he was good at anything.”

For more information about Skiers Unlimited, contact Stephen Balcanoff at sbalcan@connecticutchildrens.org.
Sonia Chaudhry, MD  
Orthopaedics
- Fellowship in pediatric orthopaedics, Hospital for Sick Children (SickKids)
- Residency in orthopaedic surgery, New York University Hospital for Joint Diseases
- MD, Thomas Jefferson Medical College
- BS, Pennsylvania State University

Kathy Kalkbrenner, MD, FAAP  
Hospital Medicine
- Fellowship in pediatric critical care medicine, Columbia University – Children's Hospital of New York-Presbyterian
- Residency in pediatrics, University of Connecticut School of Medicine – Connecticut Children’s Medical Center
- Attending physician, Schneider Children's Hospital, North Shore-Long Island Jewish Health System
- Director, Pediatric Sedation Program, New Hampshire's Hospital for Children/Elliot Hospital
- MD, University of Massachusetts Medical School
- BA, Boston University

Meghna Misra, MD  
General Surgery
- Fellowship in pediatric surgery, Oregon Health and Science University
- Residency in general surgery, Beth Israel Deaconess Medical Center
- MD, Tufts University School of Medicine
- BA, Amherst College

Christine Cornachio, MD  
Emergency Medicine
- Residency in pediatrics, The New York Presbyterian Hospital
- MD, State University of New York at Stony Brook
- BS, New York University

Brooke Davey, MD  
Cardiology
- Advanced fellowship in noninvasive cardiac imaging, University of Pennsylvania – The Children's Hospital of Philadelphia
- Fellowship in pediatric cardiology, University of Pennsylvania – The Children's Hospital of Philadelphia
- Residency in pediatrics, Columbia University – Morgan Stanley Children's Hospital of New York
- MD, New York University School of Medicine
- BA, University of Notre Dame

Mohsen Karimi, MD  
Cardiology
- Chief of Congenital Cardiac Surgery, Medical College of Georgia/Children’s Medical Center
- Assistant professor of surgery, Rainbow Babies & Children’s Hospital
- Fellowship in cardiothoracic surgery, Children’s Healthcare of Atlanta, Egleston Hospital
- Residency in cardiothoracic surgery, University of Iowa Hospitals and Clinics
- Residency in general surgery, University of Iowa Hospitals and Clinics
- MD, Indiana University School of Medicine
- MS, Indiana University-Purdue University Indianapolis
- BS, Indiana University

Tregony Simoneau, MD  
Pulmonology
- Attending physician, Boston Children's Hospital
- Fellowship in pediatric pulmonology, Boston Children’s Hospital
- Residency in pediatrics, Boston Medical Center
- Residency in medicine, Boston Children's Hospital
- MD, Stanford University
- BA, Amherst College

Meghna Misra, MD  
General Surgery
- Fellowship in pediatric surgery, Oregon Health and Science University
- Residency in general surgery, Beth Israel Deaconess Medical Center
- MD, Tufts University School of Medicine
- BA, Amherst College

Shailendra Upadhyah, MD  
Cardiology
- Fellowship in adult congenital heart disease and pulmonary hypertension, Harvard Medical School, Brigham and Women’s Hospital/Boston Children’s Hospital
- Fellowship in clinical pediatric cardiovascular electrophysiology, Medical University of South Carolina
- Fellowship in pediatric cardiology, Steven & Alexandra Cohen Children's Medical Center of New York/North Shore-Long Island Jewish Health System
- Residency in internal medicine and pediatrics, Yale University-Bridgeport Hospital, Yale-New Haven Health
- Postgraduate study, general (internal) medicine, P.D. Hinduja National Hospital and Medical Research Center
- Resident medical officer, general (internal) medicine, K.J. Somaiya Hospital and Medical Research Center
- MD, University of Mumbai/K.J. Somaiya Medical College

Sherene Mason, MD, MBA  
Nephrology
- Fellowship in pediatric nephrology, Yale University School of Medicine
- Residency in pediatrics, Yale-New Haven Children’s Hospital
- MD, MBA, University of Connecticut School of Medicine
- BSc, University of Connecticut

Kathy Kalkbrenner, MD, FAAP  
Hospital Medicine
- Fellowship in pediatric critical care medicine, Columbia University – Children’s Hospital of New York-Presbyterian
- Residency in pediatrics, University of Connecticut School of Medicine – Connecticut Children’s Medical Center
- Attending physician, Schneider Children's Hospital, North Shore-Long Island Jewish Health System
- Director, Pediatric Sedation Program, New Hampshire's Hospital for Children/Elliot Hospital
- MD, University of Massachusetts Medical School
- BA, Boston University
New Guidelines to Help with Tympanostomy Tube Decisions

As the weather turns colder, more and more children present with concerns regarding ear infections and fluid in the middle ear. This can be troubling for parents who are often dealing with multiple visits to the primary care physician or specialist, worrying about effects on hearing and speech and struggling with decisions regarding surgical intervention. Recent guidelines released by the American Academy of Otolaryngology – Head and Neck Surgery were developed by a multidisciplinary group that included adult and pediatric otolaryngologists, pediatricians, anesthesiologist, audiologists and speech language pathologists. They represent the first “evidence-based guidelines” for this exceedingly common condition and procedure.

The guidelines cover care for children ages 6 months to 12 years, help guide decisions regarding treatment of ear infections and specifically aim to clarify for whom tympanostomy tubes will be most beneficial. The key recommendations include:

- Many children with otitis media with effusion, or OME, get better on their own, especially when the fluid is present for less than three months.
- Children with persistent OME for three months or longer should get an age-appropriate hearing test.
- Tympanostomy tubes should be offered to children with hearing difficulties and OME in both ears for at least three months, because the fluid usually persists, and inserting tubes will improve hearing and quality of life.
- Tympanostomy tubes may be offered to children with OME lasting at least three months in one or both ears, and with symptoms that are likely attributable to OME, including: vestibular problems, poor school performance, behavioral problems, ear discomfort or reduced quality of life.
- Tympanostomy tubes should not be performed in children with recurrent ear infections (AOM) who do not have middle-ear effusion.

In contrast, tympanostomy tubes should be offered when middle-ear effusion is present because the tubes will prevent most future AOM episodes and will allow episodes that do occur to be treated more safely, with ear drops instead of oral antibiotics.

- Tympanostomy tubes may be offered to children who are at risk for developmental difficulties when OME is present in one or both ears and is unlikely to resolve quickly. This includes children with permanent hearing loss, speech/language delays or disorders, autism-spectrum disorder, Down syndrome, craniofacial disorders, cleft palate and/or developmental delay.
- Ear infections that occur in children with tympanostomy tubes should be treated with topical antibiotic ear drops only, not with systemic antibiotics, since drops are more effective and have fewer side effects.
- Children with tubes can usually swim or bathe without earplugs, headbands or other precautions.

Over 660,000 tympanostomy tube procedures are performed on children in the United States annually. Despite how common the procedure is, it can still be a cause for worry and concern for parents and caregivers. These guidelines should help to ease some of those concerns and fears.

As you see patients whom you feel should be evaluated for tympanostomy tubes, please call 860.545.9650 for an appointment. Additionally, Connecticut Children’s Medical Center has several referral guidelines to help you manage common pediatric conditions that may require subspecialty referral. They are available at www.connecticutchildrens.org.

With three locations, six physicians and three advanced practice clinicians, accessibility for Connecticut Children’s ENT has never been better. We look forward to working together to meet your patients’ needs.

When Hearing Loss Isn’t Just Middle Ear Effusion

Although middle-ear fluid is the most common cause of hearing loss, there are other more significant reasons that children can have difficulty hearing. Non-syndromic, congenital sensorineural hearing loss is the most common cause of hearing loss not associated with middle-ear effusion. This is usually due to genetic abnormalities and may result in a wide range of hearing loss presentations. To help identify these children, effective and routine screening should be performed on all children starting in the newborn period. Those with risk factors such as prolonged NICU stay, low birth weight, severe jaundice, IV antibiotic use and perinatal infections should be screened more frequently and for a longer period of time. If hearing loss is uncovered, whether it be mild or profound, it is important to have children evaluated so that they can receive the appropriate tools to help with hearing and subsequently with speech, language and communication. Our physicians and audiologists specialize in the medical and surgical management of pediatric hearing loss.

If the hearing loss is very severe, the child may be referred to our cochlear implant team. This team includes our two implant surgeons, Scott Schoem, MD, FAAP, and Christopher Grindle, MD, FAAP; audiologists; speech and language pathologists and deaf educators who are committed to working with children and their families to determine the best communication strategies to fit their specific needs. After implantation, the team works with patients and families to help them learn how to use their devices so as to develop or re-establish hearing, speech and language. It is through this team approach that patients and families are able to get the most out of their new technology.

Introducing Valerie Cote, MD, FRCS(C)

The division of Otolaryngology – Head and Neck Surgery at Connecticut Children’s is proud to welcome its newest physician, Valerie Cote, MD, FRCS(C). Valerie joined the division in April of 2013. She started her training at McGill University Faculty of Medicine in Montreal, Quebec, Canada. She earned her MD in 2006 and finished her residency in 2011. She then completed a fellowship in pediatric otolaryngology at the University of Colorado in 2012. She is a Fellow of the Royal College of Physicians and Surgeons of Canada in Otolaryngology – Head and Neck Surgery. She has particular interest in the diagnosis and treatment of craniofacial abnormalities, cleft lip and palate surgery, mandibular distraction, velopharyngeal insufficiency, pediatric reflux, and head and neck surgery.
The newly established Connecticut Human Milk Research Center at Connecticut Children’s recently published its inaugural paper. This first-of-its-kind study, published in the Journal of Human Lactation, observed a lack of standardized data collection at donor milk banks across North America. The findings do not call into question the milk’s safety, but rather inconsistencies in obtaining critical information about how milk is categorized and distributed.

While donor human milk undergoes extensive screening and testing to ensure its safety, milk banks affiliated with the Human Milk Banking Association of North America do not collect consistent data regarding milk donors and milk bank operations. The study’s authors conclude that “this lack of standardization and transparency may deter implementation of donor milk programs in the neonatal intensive care unit setting and hinder benchmarking, research and quality improvement initiatives.”

“At the end of the day, neonatologists, nurses, parents and public health professionals all want to make sure babies receive the best care and medicine possible, and this includes human milk,” says Elizabeth Brownell, PhD, MA, perinatal epidemiologist and director of the Connecticut Human Milk Research Center. “Given the inconsistent preterm and term milk definitions between sites, we suggest all NICUs with formal donor human milk programs clarify this information when ordering milk from all HMBANA-affiliated milk banks so they may fortify the milk accordingly.”

In 2010, the Food and Drug Administration recognized the need to develop a centralized registry to collect and disseminate standardized data. This registry still does not exist. Dr. Brownell suggests HMBANA-affiliated milk banks work with leadership and/or academic researchers to develop this registry as soon as possible. Oversight by the FDA could help increase accountability and expedite this process.

Elizabeth Brownell, PhD, MA, is also assistant professor of pediatrics at the University of Connecticut School of Medicine. She may be reached at ebrownell@connecticutchildrens.org.
Connecticut Children’s Medical Center At Your Service
Connecticut Children’s provides a variety of services at locations statewide and beyond. Here’s a summary:

**HOspitals**

**Hartford**
Connecticut Children’s Medical Center
282 Washington Street
Hartford, CT 06106

**Waterbury**
Connecticut Children’s – Waterbury
Saint Mary’s Hospital
56 Franklin Street
Waterbury, CT 06706

**NEONATAL INTENSIVE CARE UNITS (NICU)**

**Hartford**
Connecticut Children’s NICU
Hartford Hospital
80 Seymour Street
Hartford, CT 06106

**Farmington**
Connecticut Children’s NICU at UCONN Health Center
263 Farmington Avenue
Farmington, CT 06032

**AMBULATORY SURGERY CENTER**

**Farmington**
505 Farmington Ave, 3rd Floor
Farmington, CT 06032

**Specialty Care Centers**

**The Children’s Health and Wellness Center**
79 Sandpit Road
Danbury, CT 06810

**95 Reef Road**
Fairfield, CT 06824

**399 Farmington Avenue**
Farmington, CT 06032

**310 Western Boulevard**
Glastonbury, CT 06033

**4 Corporate Drive, Suite 282**
Shelton, CT 06484

**Other Locations**

**East Hartford**
111 Founders Plaza
East Hartford, CT 06108

**Farmington**
11 South Road
Farmington, CT 06032

**Hartford**
100 Retreat Avenue
Medical Arts Building
Hartford, CT 06106

**New Britain**
The Hospital of Central Connecticut
100 Grand Street
New Britain, CT 06050

**New London**
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

**Putnam**
Day Kimball Hospital
320 Pomfret Street
Putnam, CT 06260

**Stamford**
Stamford Hospital – Tully Health Center
32 Strawberry Hill Court
Stamford, CT 06902

**Torrington**
Charlotte Hungerford Hospital
157 Litchfield Street
Torrington, CT 06790

**Waterbury**
Waterbury Hospital
64 Robbins Street, 3rd Floor
Waterbury, CT 06708

**Springfield, MA**
Shriners Hospital for Children
576 Carew Street
Springfield, MA 01104

To make an appointment, call the specialty’s main number found at WWW.CONNECTICUTCHILDREN.ORG

Best Children’s Hospitals

U.S. News & World Report

RANKED IN 6 SPECIALTIES

2013–14