PEDIATRIC DERMATOLOGY REFERRAL REQUEST FORM

Children's Hospital of Philadelphia®
Dermatology

This form should be completed by a healthcare professional familiar with the child's condition.

We will make every effort to fulfill your request. However, please understand our need to triage the urgency of all requests. Completing this form does not guarantee a patient appointment. Our reviewing staff may make additional recommendations to the referring provider before the patient is seen.

*** If you would like to talk with a dermatology attending physician directly about a case, please call 1-800-TRY-CHOP. ***

Today's date _____ _____ _____
month *day* *year*

ABOUT THE REFERRER

Referring physician name and specialty: _____ _____
name *specialty*

Referring physician's phone number (and extension, if applicable): _____

Referring physician's email address: _____

ABOUT THE PATIENT

Name of child: _____ _____ DOB: _____ _____ _____
first name *last name* *month* *day* *year*

Contact name of parent or guardian: _____ Phone: _____

Is an interpreter needed? ☐ yes ☐ no If yes, for which language? _____

Insurance carrier: _____

PLEASE NOTE: *CHOP Dermatology does NOT accept the following insurance plans: UHCCP of NJ, Horizon NJ Health and Amerigroup of NJ.*

Why are you seeking a dermatology consult? Dermatology concern: _____

Background information:

Onset of symptoms:

Location and distribution:

Associated symptoms:

Progression:

Prior treatments and response:

Suspected diagnosis:

Results of prior tests or biopsies:

+ If available, please provide copies of any relevant tests or biopsy reports

Please attach a copy of the patient's insurance care (front and back) and current demographic information sheet. Please email **dermatologyreferrals@chop.edu** or return by fax to **215-590-6555.** Forms will be reviewed within 2 business days.

For Dermatology Use Only

Review date _____ _____ _____
month *day* *year*

Request reviewed by: _____ _____
first name *last name*

RECOMMENDATIONS

☐ Additional diagnostic testing, specifically

☐ Interim treatment recommendations

DISPOSITION

☐ Consider consultation with alternative subspecialist

☐ Appointment to be scheduled with CHOP Pediatric Dermatology within

☐ Other:

☐ Patient scheduled on _____ with _____

☐ *At least two unsuccessful attempts were made to contact the caregiver using the contact information provided. If the patient still requires an appointment, please have your office contact the family directly to request a return call to the Dermatology Office at 215-590-2169.*

Children's Hospital of Philadelphia®
Dermatology