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

PLEASE COMPLETE ALL OF THE FOLLOWING QUESTIONS OR THE FORM WILL BE RETURNED; DELAYING YOUR PATIENT BEING SEEN.

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.*

Pertinent past medical history:

Onset of symptoms:

Location and description:

Prior treatments and response:

Suspected diagnosis:

Results of prior tests or biopsies *(If available, please provide copies of any relevant tests or biopsy reports)*:

How soon do you need this patient seen? ☐ Urgently ☐ Next Available

Please attach a copy of the patient's insurance card (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.