



# The Children's Hospital of Philadelphia®

## **Pediatric Dermatology Expedited Appointment Request**

*This form should be completed by a health care professional familiar with this child's condition.  
This form should be completed in its entirety.*

*Please note that submission of this form does NOT guarantee an expedited appointment.  
This form will be reviewed by the dermatologist on call.*

Today's Date \_\_\_\_\_ Requesting Physician and Specialty \_\_\_\_\_

Requesting Physician Telephone Number \_\_\_\_\_

\*\* (Please provide number for nurse or office manager and not general office number)

Name of Child \_\_\_\_\_ DOB \_\_\_\_\_ Gender: M F

Contact Information for Parent or Guardian

Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

\*\* (Please note that Children's Health Care Associates does not accept Health Partners or Horizon NJ Health)

Reason for Request \_\_\_\_\_

**\* Please describe the rash or lesion in detail, including onset, associated symptoms, morphology, and progression.**

**\* Please list prior treatments and response to therapy. Please be as specific as possible and list exact names of any topical steroids, antibiotics, or other medications used.**

**\* What diagnoses have you considered?**

**\* Please list the name and specialty of any other physicians the child has seen for this problem. Please fax copy of consultation letter.**

**\* Have any tests or biopsies been performed ? If yes, what were the results ? Please fax copies of all test results.**

Skin biopsy YES NO  
Results:

X-ray, CT scan, ultrasound, or MRI YES NO  
Results:

Blood tests YES NO  
Results:

Patch tests YES NO  
Results:

Allergy skin tests YES NO  
Results:

**MEDICAL HISTORY:**

Has the child's growth and development been normal? If no, please explain YES NO

Does the child have any medical conditions? If yes, please list YES NO

Is the child taking any medications? If yes, please list YES NO

Has the child ever been hospitalized or had surgery? If yes, please list YES NO

**Copies of all results, including skin biopsies, radiologic studies, specialist consultation, and blood and allergy testing must accompany this form.**

**This form will not be reviewed until all records are received.**

**Please fax completed form and all prior results to 215-590-4948.**

**Forms will be reviewed within 72 hours.**

**Pediatric Dermatology Expedited Appointment Request – Dermatology Attending Disposition**

Today's Date \_\_\_\_\_ Request reviewed by Dr. Shah / Treat / Yan

Requesting Physician and Specialty \_\_\_\_\_

Name of Child \_\_\_\_\_ DOB \_\_\_\_\_ Gender: M F

Reason for Request : \_\_\_\_\_

Assessment:

**Recommendations:**

Additional diagnostic testing recommended :

Treatment recommendations :

More clinical information requested :

**Disposition:**

Referral to Subspecialist : \_\_\_\_\_

Referral to General Dermatologist

Schedule appointment with CHOP Pediatric Dermatology within :  
 1 week  
 2 weeks  
 1 month  
 3 months  
 Routine

**NOTES:**

Appointment scheduled in CHOP Pediatric Dermatology on \_\_\_\_\_ with Dr. \_\_\_\_\_

DME / NH / SS Date completed : \_\_\_\_\_