PEDIATRIC DERMATOLOGY EXPEDITED APPOINTMENT 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 expedite 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: _____ Pediatrics
name *specialty*

Referring physician's phone number (and extension, if applicable): 215-427-5985

Referring physician's email address: n/a; Mailing address: 160 E. Erie Ave., Phila., PA 19134

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 card (front and back) and current demographic information sheet.
- Please email dermimagingreferrals@chop.edu. 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 expedited appointment, please have your office contact the family directly to request a return call to the Dermatology Office at 215-590-2169.*

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