Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Dear Referring Doctor,

To complete our mission as a tertiary care center and in order to provide you with the best possible service we are requesting that you kindly complete our **REFERRAL TRIAGE FORM which follows.** Please note that any incomplete or illegible form will not be processed and will be returned, resulting in delays.

In case of any URGENT consultation that needs to be seen within one week please contact the Montreal Children's Hospital (MCH) Call Center at 514-412-4400 extension 53333 and ask to speak to the dermatologist on call.

Thank you for your collaboration,

Montreal Children's Hospital

Department of Pediatrics

Division of Dermatology

Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Montreal Children's Hospital
2300 Rue Tupper, Montréal, QC H3H 1P3
(514) 412-4400
Date of Request: ______________________________

REFERRING PROFESSIONAL INFORMATION:	
Name of Referring Physician:	
License #:	
Mailing Address:	
Tel:	**Fax:**

PATIENT INFORMATION:	
Family name:	**First name:**
Date of birth:	☐Male ☐Female
Montreal Children's Hospital MRN (if available):	
Name of parent or guardian:	
Contact telephone number:	
Interpreter needed: ☐Yes ☐No	**If yes, language of interpreter:**
Relevant medical history:	

☐ Immunosupression	☐ Active Cancer	☐ Treated Cancer

REASON FOR CONSULT REQUEST:			
☐ Eczema	☐ Acne	☐ Tinea Capitis	☐ Nail Changes
☐ Hair Loss	☐ White Spots	☐ Brown Spots	☐ Changing Mole

Others:

If unsure about diagnosis please describe physical findings as best you can :

Duration of problem:	☐ <1 month	☐ 1-3 months	☐ 3-6 months	☐ >6 months

Affected area:

☐ Scalp	☐ Trunk	☐ Limbs	
☐ Face and neck	☐ Genital Area	☐ Nails	

Other (please specify):

Have any investigations been performed to work-up this condition (blood work, imaging, etc…)?
☐Yes ☐No

If yes, please include the results in your referral.

Treatment(s) received for this specific referral:				
Medication	**Duration**	**Response**	**Currently in Use**	
______	______	______	☐Yes ☐No	
______	______	______	☐Yes ☐No	
______	______	______	☐Yes ☐No	
______	______	______	☐Yes ☐No	

Additional comments:

____

____

____

____

____ ______________________

Signature of referring physician Date