Hartford Dermatology Associates, P.C. • Pediatric Dermatology of New England

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Consultation Request Form

Please complete all of the requested information below. Please DO NOT send pediatric well child office notes or documents unrelated to immediate dermatologic concerns.

Patient Name _____ **DOB** _____

Address _____

City, State, ZIP _____

Parent Name _____ **Telephone #** _____ **home/ work/ cell**

Parent Name _____ **Telephone #** _____ **home/ work/ cell**

Insurance: _____

ID Number: _____ **Subscriber Name** _____

If a referral is required, please fax or mail it to us prior to your appointment.

Requesting Physician's Name: _____

Specialty: _____ **NPI#:** _____

Street Address: _____

City, State, ZIP: _____

Phone: _____ **Fax:** _____

Reason for consultation. ***Send pertinent biopsy and lab reports. Please DO NOT SEND well child office visits, immunization history, etc.***

_____

_____

_____

_____

_____

Date of onset of above dermatologic issue: _____

Therapy/medications used: _____

_____

_____

Pain/itching	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Bleeding	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**
Sleeping difficulty	☐ **None**	☐ **Mild**	☐ **Moderate**	☐ **Severe**

If this is a dermatological problem that needs expedited scheduling, please call our office in addition to faxing this form. A parent/guardian must accompany patients under the age of 18.

Requesting physician signature: _____ **Date:** _____