Children's Hospital Pediatric Associates
Dermatology Program
Appointment Triage Form
Phone: (617) 355-6117
Fax: (617) 730-7545

We are asking that patients please be evaluated by their Primary Care Provider before obtaining a specialist appointment. If you have reviewed your patient's case, discussed treatment options, and feel that a specialist appointment is necessary, please complete this form and fax it to the appointment request line (617) 730-7545.

Referral Information:

Name of Clinic or Medical Facility: _____
Name of Referring Physician: _____
Contact Name: _____
Phone: _____
Fax: _____
Date: _____

Patient Information:

Last Name: _____
First Name: _____
Date of Birth: _____
Boston Children's Hospital MRN#, if applicable: _____
Parent/Guardian Name: _____
Contact Phone for Parent/Guardian: _____

Current Diagnosis and Reason for Request:

_____
_____
_____
_____
_____
_____

Please indicate if the patient is currently under the care of and/or has recently seen a Dermatologist outside of Boston Children's Hospital.

NO ☐ YES ☐ Provider's Name: _____

Has the patient had a biopsy or blood work done for this condition?

NO ☐ YES ☐ If yes, please include these relevant reports

Please indicate the patient's preferred visit location:

Boston ☐ Lexington ☐ Peabody ☐ Waltham ☐ Weymouth ☐

All forms must be signed by the referring physician, indicating that he/she has reviewed the case and is now referring the patient to a specialist.

Signature of MD: _____