American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Specialty Consult Request

Consultant Name:
Patient Demographics: Name: Birth Date: Parent's Name: Daytime Phone: Insurance:
Clinical Problems: Diagnoses: Specific symptoms:
Specific Clinical Questions: 1. 2. 3.
Specialist Directives: ☐ Evaluate and provide treatment recommendations or opinion ☐ Evaluate and treat ☐ Assume care for this problem
Prior History, Evaluation, Therapy (fax all relevant chart notes):
Referring Practitioner (circle preferred method of communication): Name: Phone: Fax: Email: