Dear Provider,

Thank you for your referral to the Dermatology Clinic. Following, you will find our Appointment Request and Clinical Triage Form. In order for us to efficiently process your request, please read the following instructions prior to sending your referral for review:

- **PLEASE REVIEW and FOLLOW the DERMATOLOGY MANAGEMENT GUIDELINES found on the TCH website BEFORE initiating your referral.**

  Health Professionals → Refer a Patient → Select a Clinic → Dermatology Clinic

- **Please COMPLETELY fill out each field**
  - Incomplete forms will not be processed until all pertinent information is provided on the referral form. This will result in an unnecessary delay in your request.

- **DO NOT SEND MEDICAL RECORDS!**
  - If we require medical records, we will send you a request for additional information.

If this is an **URGENT** request (appointment needed within 72 hours), please contact the page operator at (832) 824-2099 and ask for dermatology to be paged. Thank you for your patience and understanding during this transition period.

    Sincerely,

    Dermatology Service
**Appointment Request and Clinical Triage Form**

**Dermatology Service**

Phone: 832-822-3720  Fax: 832-825-9018

**ONLY COMPLETED REFERRALS WILL BE REVIEWED BY OUR PEDIATRIC DERMATOLOGIST WITHIN 5 BUSINESS DAYS. PLEASE DO NOT SEND MEDICAL RECORDS**

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### Date of Request: 

### TCH MRN:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name &amp; MI</th>
<th>Age</th>
<th>Date of Birth</th>
<th>M / F</th>
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Translator needed? Yes ____ No ____  If Yes, what language? Language:

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<tr>
<th>Parent/Guardian(s)</th>
<th>Home</th>
<th>Work #</th>
<th>Cell #</th>
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Referring Physician Name (PCP and/or Subspecialist)

Practice Contact  
Office Phone  
Office Fax

### CLINICAL INFORMATION:

*Please adhere to treatment guidelines on TCH website before proceeding with referral*

http://texaschildrens.org/Refer/Dermatology/

### Reason for Referral:

- [ ] Diagnosis is in question
- [ ] Concern for other medical risks
- [ ] Not responding to TCH Dermatology Treatment Guidelines

### Description of problem (include location & duration)

- [ ]

### Treatments Tried for this problem—(Include name, dose, duration, and preparation)

- [ ]

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### Dermatology Staff Response:

APPT DATE:  
AT  
AM / PM WITH DR.

- [ ] INCOMPLETE INFORMATION
- [ ] REASON  [ ] DESCRIPTION  [ ] TREATMENT(S)
- [ ] ADDITIONAL INFORMATION REQUESTED
- [ ] LISTED NUMBERS ARE NOT WORKING: