Santé
et Services sociaux
Québec

DT9297

Patient's first and last name		
Health insurance number	Expiry Year	Month
Parent's first and last name		
Area code Phone number	Area code Phone number (alt.)	
Address		
Postal code		

GENERAL PEDIATRIC CONSULTATION

For all situations identified as priority A, contact the on-call pediatrician

Reason for consultation — **Clinical priority scale: A: ≤ 3 days B: ≤ 10 days C: ≤ 28 days D: ≤ 3 months E: ≤ 12 months**

Recommended: Growth curve for any consultation

Reason	Option	Priority
Irritability – Feeding difficulties	☐ Age < 1 month	B
	☐ Age 1–6 months	C
	☐ Age > 6 months	D
Statural and/or ponderal growth retardation	☐ Age ≤ 1 year	C
	☐ Age > 1 year	D
☐ Chronic abdominal pain/chronic diarrhea/ constipation *(Recommended: calendar of symptoms)*		D
☐ Repeated infections: respiratory, urinary, etc. *(Recommended: medical imaging report)*		D
Headache *(Recommended: calendar of symptoms)*	☐ New-onset with vomiting and normal neurological exam	B
	☐ Migraine	C
	☐ Chronic	D
Chronic cough/Asthma *(Recommended: calendar of symptoms)*	☐ Age ≤ 6 months	C
	☐ Age > 6 months	D
Heart murmur (child in stable condition)	☐ Age < 1 month	B
	☐ Age 1–3 months	C
	☐ Age > 3 months	D
Refer to CISSS or CIUSSS AGIR TÔT screening service beforehand ☐ Delayed development in a child age 0–5 *(Recommended: Agir tôt development profile and/or assessment reports, head circumference curve, speech therapist report and audiogram requested in the event of language delay)*		D
☐ Learning disability assessment – ADHD *(Prerequisite: SNAP-IV report or Conners assessment report or Poulin questionnaire or psychosocial assessment report)*		E
☐ Behavioral disturbances *(Prerequisite: psychosocial assessment requested)*		E
☐ Skull abnormality/plagiocephaly		C
☐ Cutaneous problems *(specify)*		D
☐ Enuresis		E
☐ Phimosis		E

☐ **Other reason for consultation or clinical priority modification *(MANDATORY justification in the next section)*:**

Clinical priority

Suspected diagnosis and clinical information (mandatory)

If prerequisite is needed:

☐ **Attached to this form**

☐ **Ordered**

Special needs:

Referring physician identification and point of service

Referring physician's name			Licence no.
Area code Phone no.	Extension	Area code Fax no.	
Name of point of service			
Signature		Date (year, month, day)	

Stamp

Family physician: ☐ **Same as referring physician** ☐ **Patient with no family physician**

Family physician's name

Name of point of service

Registered referral (if required)

If you would like a referral for a particular physician or point of service

Clinical alerts:

For all situations identified as clinical alerts, contact the on-call pediatrician or send the child to emergency.

Priority A:

For all situations identified as priority A, contact the on-call pediatrician.