



DT9297

GENERAL PEDIATRIC CONSULTATION

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

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

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					
Irritability – Feeding difficulties	<input type="checkbox"/> Age < 1 month	B	Heart murmur (child in stable condition)	<input type="checkbox"/> Age < 1 month	B
	<input type="checkbox"/> Age 1–6 months	C		<input type="checkbox"/> Age 1–3 months	C
	<input type="checkbox"/> Age > 6 months	D		<input type="checkbox"/> Age > 3 months	D
Statural and/or ponderal growth retardation	<input type="checkbox"/> Age ≤ 1 year	C	<input type="checkbox"/> Delayed development in a child age 0–5 <i>(Recommended: head circumference curve, speech therapist report and audiogram requested in the event of language delay)</i>	D	
	<input type="checkbox"/> Age > 1 year	D			
<input type="checkbox"/> Chronic abdominal pain/chronic diarrhea/ constipation <i>(Recommended: calendar of symptoms)</i>	D		<input type="checkbox"/> Learning disability assessment – ADHD <i>(Prerequisite: SNAP-IV report or Conners assessment report or Poulin questionnaire or psychosocial assessment report)</i>	E	
<input type="checkbox"/> Repeated infections: respiratory, urinary, etc. <i>(Recommended: medical imaging report)</i>	D		<input type="checkbox"/> Behavioral disturbances <i>(Prerequisite: psychosocial assessment requested)</i>	E	
Headache <i>(Recommended: calendar of symptoms)</i>	<input type="checkbox"/> New-onset with vomiting and normal neurological exam <input type="checkbox"/> Migraine <input type="checkbox"/> Chronic	B	<input type="checkbox"/> Skull abnormality/plagiocephaly	C	
		C	<input type="checkbox"/> Cutaneous problems <i>(specify)</i>	D	
		D	<input type="checkbox"/> Enuresis	E	
Chronic cough/Asthma <i>(Recommended: calendar of symptoms)</i>	<input type="checkbox"/> Age ≤ 6 months	C	<input type="checkbox"/> Phimosi	E	
	<input type="checkbox"/> Age > 6 months	D			
<input type="checkbox"/> Other reason for consultation or clinical priority modification <i>(MANDATORY justification in the next section):</i>				Clinical priority	
Suspected diagnosis and clinical information (mandatory)			If prerequisite is needed:		
			<input type="checkbox"/> Attached to this form <input type="checkbox"/> Ordered		
Special needs:					
Referring physician identification and point of service				Stamp	
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)		
Family physician: <input type="checkbox"/> Same as referring physician <input type="checkbox"/> Patient with no family physician				Registered referral (if required)	
Family physician's name				If you would like a referral for a particular physician or point of service	
Name of 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.