# DR. ASHLEY MACKEY, CONSULTANT PEDIATRICIAN

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## PEDIATRIC CONSULTATION REQUEST

NAME OF PATIENT: _____

SEX: M ☐ F ☐ ADDRESS: _____ PHONE: _____

HEALTH NUMBER: _____

(Please check and complete)

GENERAL:

- ☐ Failure to Thrive
- ☐ Developmental Delay
- ☐ Chronic Disease
- ☐ Chronic Rash
- ☐ Asthma/Chronic Cough
- ☐ Seizures
- ☐ Headaches
- ☐ Abdominal Pain
- ☐ Diabetes
- ☐ Pubertal Issues
- ☐ Recurrent Infections
- ☐ Joint Pain
- ☐ Genetic Syndrome
- ☐ Recent Admission
- ☐ Vaccine Counselling

INFANT ISSUES:

- ☐ Sleep
- ☐ Feeding
- ☐ Irritability / Colic
- ☐ Reflux / Vomiting
- ☐ Prematurity / Low Birth Weight
- ☐ Congenital

TODDLER ISSUES:

- ☐ Toilet Training/Bedwetting
- ☐ Constipation/Encopresis
- ☐ Nutrition/Picky Eating
- ☐ Behaviour Concerns
- ☐ Autism

SCHOOL AGE ISSUES:

- ☐ Attention/Hyperactivity
- ☐ Learning Disorder/School Concerns
- ☐ Behaviour Concerns
- ☐ Autism

ADOLESCENT ISSUES:

- ☐ Behaviour Concerns
- ☐ Eating Concerns
- ☐ High Risk Behaviour
- ☐ Mental Illness
- ☐ Amenorrhea
- ☐ Mood Disorder

OTHER (Please provide reason for referral & pertinent clinical information)

_____

_____

Referring Physician Signature _____ Billing Number _____

Referring Physician Name (Please Print) _____ Date _____

Phone _____ Fax _____

**Use of this form is NOT mandatory for consultation requests**