Pediatric General Surgery Referral Form

SUBSPECIALTY

◯ Antenatal ◯ Neonatal (0-28 Days) ◯ General Pediatrics

A — ANTENATAL

Gestational Age (In Weeks):

Estimated Due Date:

Anomaly (select all that apply):

☐ Fetal Surgical Anomaly ☐ Imaging Abnormality ☐ Genetic (MSS/Amnio/CVS) ☐ Amniotic ☐ Unknown

Details:

Termination Consideration:

◯ Yes ◯ No

Termination Deadline:

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

B — NEONATAL (0-28 DAYS)

Reason for Referral (select one):

◯ Hydrocele ◯ Inguinal Hernia ◯ Undescended Testicle ◯ Genitourinary ◯ Feeding Difficulties ◯ Umbilical Drainage/Discharge
◯ Neck Mass ◯ Other

If 'Inguinal Hernia':

CONTACT SURGEON ON CALL IF YOU SUSPECT INCARCERATED HERNIA

◯ Symptomatic ◯ Asymptomatic

Details:

If 'Undescended Testicle':

Select all that apply:

☐ Unilateral ☐ Bilateral ☐ Palpable ☐ Non Palpable

If 'Feeding Difficulties':

Select all that apply:

☐ Enteral Tube Feed Dependance ☐ Poor or Unsafe Feeding ☐ GERD ☐ Aspiration Events/Pneumonia ☐ Other

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C — GENERAL PEDIATRICS (complete if General Pediatrics selected)

Referral Category (select one — complete matching section below or on pages 3–8):

◯ Integumentary/Soft Tissue/MSK ◯ Abdominal Wall ◯ Gastrointestinal ◯ Oropharyngeal/Neck ◯ Thoracic ◯ Genitourinary
◯ Request for Vascular Access (EXCLUDES PICC LINES) ◯ Other

C1 — INTEGUMENTARY / SOFT TISSUE / MSK

Reason for Referral (select one):

◯ Skin Lesion ◯ Soft Tissue Lump/Mass (Inc. breast lump) ◯ Ingrown Toenail ◯ Plantar Wart(s) ◯ Pilonidal Disease
◯ Vascular Lesion ◯ Wound Management ◯ Other (Specify)

Duration:

Symptomatic:

◯ Yes ◯ No

If Symptomatic — select all that apply:

☐ Pain ☐ Pruritis ☐ Bleeding

Infection:

◯ Yes ◯ No

If Infection:

◯ Active ◯ Prior ◯ Recurrent

Changing:

◯ Yes ◯ No

If Changing — select all that apply:

☐ Size ☐ Color ☐ Border

Size (mm or describe):

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C2 — ABDOMINAL WALL

Reason for Referral (select one):

◯ Hernia ◯ Hydrocele ◯ Umbilical Drainage/Discharge ◯ Other (Specify)

If 'Hernia':

Symptomatic:

◯ Yes ◯ No

Type/Location:

◯ Inguinal Hernia (DEFER DECISION FOR ULTRASOUND TO SPECIALIST ASSESSMENT)
◯ Umbilical Hernia (NO ULTRASOUND REQUIRED PRIOR TO REFERRAL)

Other Hernias:

◯ Epigastric ◯ Ventral ◯ Incisional ◯ Other

Explain:

If 'Umbilical Drainage/Discharge':

Active Drainage:

◯ Yes ◯ No

Duration:

Local Infection:

◯ Active ◯ Prior

If 'Hydrocele' — Comments:

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C3 — GASTROINTESTINAL

Reason for Referral (select one):

◯ Feeding Difficulties ◯ Foregut (Solid Organs) ◯ GI Signs & Symptoms NYD

If 'Feeding Difficulties':

G Tube Consideration +/- Fundoplication (select all that apply):

- ☐ Dysphagia
- ☐ Poor or Unsafe Feeding (eg: Uncoordinated Swallowing)
- ☐ Aspiration Events/Pneumonia
- ☐ Weight Loss
- ☐ Enteral Tube Feed Dependence
- ☐ GERD/Vomiting (Non-bilious)
- ☐ Worsening Food Fear / Avoidance

If 'Weight Loss' selected:

◯ Yes — Weight Loss >/= 10% or Crossing 2 Curves on Growth Chart ◯ No

Details:

Onset:

Duration of Symptoms:

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C3 — GASTROINTESTINAL: If 'Foregut (Solid Organs)'

Symptomatic:

◯ Yes ◯ No

If Symptomatic — Yes:

Previous ER Visit or Hospital Admission:

◯ Yes ◯ No ◯ Uncertain

Associated Fever, Jaundice, Bruising or Petechiae:

◯ Yes ◯ No

Details:

Onset of Symptoms:

Duration of Symptoms:

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C3 — GASTROINTESTINAL: If 'GI Signs & Symptoms NYD'

Select all that apply:

- ☐ Abdominal Pain
- ☐ Vomiting or GERD
- ☐ Diarrhea
- ☐ Perianal Disease
- ☐ Abdominal Mass
- ☐ Abdominal Distention
- ☐ Stooling Difficulties
- ☐ Blood in Stool (Rectal Bleeding)
- ☐ Weight Loss
- ☐ Other

If 'Vomiting or GERD' — Bilious (Green) Emesis:

◯ Yes ◯ No

If 'Stooling Difficulties' — Difficulty With:

◯ History of Active Constipation (Based on Rome Criteria and Bristol Stool Chart) ◯ Encopresis ◯ Other

If 'Blood in Stool' — Color: ◯ Melena ◯ Maroon ◯ Bright Red

◯ Painful: Yes ◯ No

If 'Perianal Disease' — Choose all that apply:

☐ Abscess ☐ Polyps (Skin Tags) ☐ Fistula ☐ Hemorrhoids

◯ Recurrent: Yes ◯ No

If 'Weight Loss' — Is Weight Loss >/= 10% or Crossing 2 Curves on Growth Chart:

◯ Yes ◯ No

If 'Abdominal Mass':

Location (select all that apply):

☐ Left ☐ Right ☐ Epigastric ☐ Mid-Abdomen ☐ Suprapubic

Size When First Noticed: _____

◯ GI Associated Symptoms: Yes ◯ No ◯ Uncertain

◯ Urinary Symptoms (Dysuria/Hematuria): Yes ◯ No ◯ Uncertain

◯ Mobile: Yes ◯ No ◯ Uncertain

◯ Changing: Yes ◯ No ◯ Uncertain

Current Size: _____

◯ Imaging Ordered: Yes ◯ No

◯ Imaging Performed: Yes ◯ No

Details:

Onset:

Duration:

Referral Type:

◯ New Referral ◯ Update to Existing Referral

Comments:

C4 — OROPHARYNGEAL / NECK

Reason for Referral (select one):
◯ Ankyloglossia ◯ Mucocoele/Ranula ◯ Other (Specify)

If 'Ankyloglossia':

Feeding Issues:
◯ Yes ◯ No ◯ Uncertain

Poor Weight Gain/Weight Loss:
◯ Yes ◯ No ◯ Uncertain

Speech Concern:
◯ Yes ◯ No

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

If 'Mucocoele/Ranula':

Symptomatic:
◯ Yes ◯ No

Recurrent:
◯ Yes ◯ No

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

C5 — THORACIC

Reason for Referral (select one):
◯ Chest Wall Deformities ◯ Lung or Diaphragm Abnormalities ◯ Complicated Pneumonia ◯ Pneumothorax ◯ Mediastinal Mass
◯ Other (Specify)

If 'Chest Wall Deformities' or 'Pneumothorax' or 'Other':

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

If 'Lung or Diaphragm Abnormalities':

Respiratory Concerns:
◯ Yes ◯ No ◯ Uncertain

Frequency of Pneumonia:
◯ None ◯ One Episode ◯ >1 Episode

Imaging Ordered:
◯ Yes ◯ No

Imaging Performed:
◯ Yes ◯ No

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

C5 — THORACIC (continued from page 5)

If 'Complicated Pneumonia':

Duration of Symptoms:

Duration of Parenteral Antibiotics:

Respiratory Concerns:
◯ Yes ◯ No

Ongoing Fever:
◯ Yes ◯ No

Imaging Ordered:
◯ Yes ◯ No

If Imaging Ordered — What type:
◯ Plain Radiographs ◯ Ultrasound

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

If 'Mediastinal Mass':

Choose:
◯ Incidental (Imaging) ◯ Symptomatic (Respiratory Concerns or B-Symptoms) ◯ Other

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

C6 — GENITOURINARY

Reasons for Genitourinary (select one):
◯ Urinary Tract Infection ◯ Circumcision ◯ Undescended Testicle ◯ Ovarian Concern ◯ Non Retractable Foreskin (Phimosis)
◯ Other

If 'Undescended Testicle':

Since birth:
◯ Yes ◯ No ◯ Uncertain

Laterality:
◯ Unilateral ◯ Bilateral

Palpable:
◯ Yes ◯ No

If palpable: No Ultrasound Required
If not palpable: Defer to Specialist Assessment

Testicular or scrotal concern:
◯ Yes ◯ No

Signs and Symptoms (select all that apply):
☐ Pain ☐ Redness ☐ Swelling ☐ Palpable Mass

Imaging Performed:
◯ Yes ◯ No

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

If 'Urinary Tract Infection':

Frequency:
◯ Single UTI ◯ More than 1 UTI

Urine Culture Confirmed:
◯ Yes ◯ No

Fever during at least 1 UTI:
◯ Yes ◯ No

Renal Ultrasound Ordered:
◯ Yes ◯ No

VCUG Ordered:
◯ Yes ◯ No

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

C6 — GENITOURINARY (continued from page 6)

If 'Ovarian Concern':

Ovarian Mass:
◯ Yes ◯ No

Details:

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

If 'Non Retractable Foreskin (Phimosis)':

Normal Appearing Foreskin:
◯ Yes ◯ No ◯ Uncertain

Prior UTI's or Balanitis:
◯ Yes ◯ No

Regular ballooning of foreskin during voiding:
◯ Yes ◯ No

Prior Use of Topical Steroid Cream:
◯ Yes ◯ No ◯ Uncertain

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments:

C7 — REQUEST FOR VASCULAR ACCESS (EXCLUDES PICC LINES)

Reason for Request (select one):
◯ Insertion of Vascular Access Device (Excludes PICC Lines) ◯ Removal of Vascular Access Device (Excludes PICC Lines)

If 'Insertion of Vascular Access Device':

Reasons for Requesting Insertion of VAD (select one):
◯ Non-Urgent/Elective ◯ Type of Device Required ◯ Concurrent Procedures During Placement

If 'Non-Urgent/Elective':

Date Required / Next Scheduled Treatment:

Reasons for Request:
◯ Oncology ◯ Hematology ◯ Medical

Confirmed / Presumptive Diagnosis:

If 'Medical' — Medical Reasons:
◯ Scheduled Regular Medical Treatments ◯ Dialysis

If 'Type of Device Required':
May require special ordering — type must be known prior to scheduling
◯ Portacath ◯ Hickman (Double Lumen CVL) ◯ Hemodialysis ◯ Specific CVL ◯ CVL Type Not Yet Determined

If 'Specific CVL' — Specify: _____

If 'Concurrent Procedures During Placement':
◯ Are concurrent procedures being requested: Yes ◯ No
Early requests are required to support operative time and logistics
◯ Bone Marrow/Lumbar Puncture ◯ Echocardiogram ◯ Other

If 'Removal of Vascular Access Device':

Reasons Requesting Removal (select one):
◯ Completion of Treatment/No Longer Required ◯ Change in Treatment (Alternate VAD Required) ◯ Complicated

If 'Complicated' — Complicated Reasons:
◯ Function/Access Concerns with VAD ◯ Infection/Thrombosis

Why was the VAD inserted:
◯ Oncology ◯ Hematology ◯ Medical

Confirmed/Presumptive Diagnosis:

Will another VAD be required:
◯ Yes ◯ No

If Yes — is this repeat access:
◯ Urgent ◯ Non Urgent (>1-3 weeks)

Referral Type:
◯ New Referral ◯ Update to Existing Referral

Comments: