Information for healthcare providers

Make a referral

Referral criteria and eligibility			
Reason for referral	**Criteria**	**Mandatory information to include in referral**	**Other information**
Umbilical hernia	Persistent defect in the umbilicus, with intermittent bulging during activity, persisting **past age 4**.	-Medical comorbidities. -History of incarceration. -Associated pain with activity.	-Many umbilical hernias close spontaneously and are asymptomatic in children. -Surgical repair is usually not offered before school age. However, large hernia defects (>2cm) at the fascial level may be considered for consultation at the age of 3. -These hernias **DO NOT** require abdominal US.
Epigastric hernia	Small, intermittent, or persistent bulging anywhere in the epigastric region (between xiphoid process and umbilicus).	-Medical comorbidities. -Associated pain with activity.	-Note that epigastric hernias are very small fascial defects with a fatty protrusion and do not pose a risk for visceral incarceration.
Incisional hernia	Acquired after a previous abdominal surgical procedure.	-Medical comorbidities. -Date and type of surgical procedure. -Associated symptoms.	-Please refer back to the surgeon who originally performed the surgery. -If surgery occurred outside of CHEO, please ask family to obtain all relevant medical records of the procedure.
Inguinal hernia	Intermittent inguinal bulging, (lateral to the pubic tubercle with potential extension into scrotum or labia),	-Medical comorbidities, including history of prematurity. -History of incarceration.	-Premature babies and infants under the age of 1 carry a higher risk of inguinal hernia incarceration and

	exacerbated by activity or straining.	-Associated pain with activity/straining.	should be referred urgently. -Inguinal or scrotal US confirmation is **NOT recommended** due to its inaccuracy. -Photographs of the bulging episode taken by family may aid clinical assessment.
Hydrocele	Persistent or fluctuating scrotal swelling due to fluid.	-Medical comorbidities. -Associated inguinal bulging. -Presence at birth, vs acute presentation.	-Many hydroceles resolve by age 2 and surgical repair is not usually offered before then. -A hydrocele must however be distinguished from an inguinal hernia or acute scrotum. -A concomitant inguinal hernia will require more urgent intervention and acute scrotum requires ER presentation.
Cryptorchidism	Non-palpable testicle, ectopic testicle or palpable testicle in the inguinal canal that cannot be delivered into the scrotum **beyond 6 months of age.**	-Medical comorbidities. -Any associated inguinal hernia. -Presence of testicle at birth. -In older children please comment on scrotal symmetry.	-If concomitant inguinal hernia is suspected, please expedite the referral. -When retractile testes are suspected, it may be helpful to ask families to note whether testes are present in the scrotum during bath time.
Phimosis	Inability to retract foreskin to fully expose the glans past age 4.	-Medical comorbidities. -History of UTI or balanitis. -Ballooning of the foreskin during urination. -Previous type and duration of topical steroid trial.	-Note that most topical steroid therapy requires a minimum of 6-9 months of consistent daily use to achieve a desired effect. -aggressive foreskin retraction is not recommended below school age.

Urachal or omphalomesenteric duct remnant.	Omphalomesenteric duct remnants represent varying degrees of communication between the umbilicus and small bowel. Urachal remnants represent varying degrees of communication between the umbilicus and the bladder.	-Medical comorbidities. -History of infection -History of umbilical drainage (type and quantity) -History of other urologic anomalies.	
Ingrown Toenail	Intermittent or persistent inflammation/infection of the skin surrounding the lateral and medial aspects of a toenail.	-Medical comorbidities. -History of systemic antibiotic requirements.	-We recommend daily Epsom salt foot soaks for patients with active/chronic inflammation while awaiting consultation.
Perianal abscess/fistula	Localized abscess to the peri-anal space resulting in erythema, pain and swelling. Fistula: Intermittent or chronic drainage of purulent fluid from a localized perianal skin opening.	-Medical comorbidities. -Any antibiotics tried. -Any procedures required for drainage. -Any previous episodes. -In older children, please include a summary of any symptoms concerning for IBD such as rectal bleeding, chronic diarrhea, crampy abdominal pain, vomiting, growth failure, weight loss (5-10%) or extra-intestinal manifestations.	-PO broad spectrum antibiotics and sitz baths with Epsom salts can be tried while awaiting consultation. -Fevers or worsening pain should prompt ER visit.
Anal skin tag	Non-vascular redundancy of the anoderm.	-Medical comorbidities. -History of constipation or painful stooling. -Associated symptoms such as local skin irritation or itching.	Encourage dedicated local hygiene to reduce any associated symptoms.

Rectal bleeding	Bright red blood in stool or on toilet paper during wiping.	-Medical comorbidities. -Medications. -Stool type on Bristol chart, frequency, associated pain with defecation, weight loss (5-10%) or growth failure. -Visible peri-anal lesions such as hemorrhoids, rectal prolapse, anal fissures or polyps. -Any previous investigations or medical consultations.	-If rectal bleeding is associated with IBD symptoms, refer to GI. -If rectal bleeding is associated with constipation, refer to community pediatrics for bowel management. -Note that most anal fissures and hemorrhoidal protrusion will resolve with good bowel management.
Rectal prolapse	Full thickness protrusion of rectal mucosa during straining with bowel movements.	-Medical comorbidities (connective tissue disorders/ cystic fibrosis). -Growth failure/malnutrition. -Medications. - Stool type on Bristol chart, frequency. - Current bowel management therapy. -History of requiring reduction in ER.	
Hirschsprung's Disease	Inability to consistently pass gas or stool spontaneously since birth.	-Medical comorbidities. -Timing of 1st passage of meconium. -Episodes suspicious for enterocolitis. -Growth failure. -Chronic abdominal distension and associated vomiting. -Need for suppositories or other laxatives -Type of infant feed: exclusive breast-feeding vs formula, including any recent change in formula. -Any investigations.	

Functional constipation	-Hard, infrequent stooling that may be associated with abdominal pain or painful stooling. -Not associated with delayed passage of meconium, growth failure, enterocolitis or difficulty passing gas. -Common ages of onset: toddler (toilet training)/school entry.		-Refer to community pediatrics -Link to constipation management CHEO website.
Pilonidal disease	Midline gluteal cleft skin pits containing hair that may be associated with intermittent or chronic local infection/pain.	-Medical comorbidities. -Medications. -Incidence and frequency of infection and any treatment strategies tried.	-Recommend aggressive and dedicated local hygiene and local hair removal while awaiting consultation.
Anorectal malformation	Absence of or abnormal location or caliber of anus.	-Medical comorbidities, especially known VACTERL anomalies (vertebral, cardiac, tracheo-esophageal, renal or limb anomalies) -If a child had an ARM treated at an outside institution and requires ongoing follow up care, please include all relevant previous medical records/investigations. Please also include current bowel management plan and stooling pattern.	-Note that the complete absence of an anus at birth warrants urgent hospitalization.
Request for Gastrostomy tube	Unsafe swallowing, prolonged tube feeding requirement or persistently inadequate PO intake resulting in growth failure.	-Medical comorbidities. -Medications. -Investigations leading to swallowing safety concerns.	

		-Evidence of growth failure. -Duration of tube feeding requirement. -Expected duration of enteral tube feeding. -Prognosis of underlying condition.	
Gastroesophageal reflux	The reflux of stomach contents into the esophagus.	-Medical comorbidities. -Existing medications and type/duration of medications tried. -Description of symptoms, including type and volume of emesis. -Any complications (aspiration, pneumonia, hematemesis, failure to thrive, blue spells) -Any previous endoscopy.	Initial referral should be to community pediatrics unless complications have occurred despite optimized medical management.
Symptomatic gallstones	Examples include: biliary colic, history of cholecystitis, choledocholithiasis or gallstone pancreatitis.	-Medical comorbidities (obesity, hemolytic anemia, history of prematurity, TPN, contraceptives, previous intestinal resection). -Medications. -Description of symptoms – frequency, duration, and association with meals. -Stool type (Bristol stool chart) -Associated jaundice.	Note that choledocholithiasis or concerns for gallstone pancreatitis require presentation to ER.
Esophageal anomalies	History of esophageal atresia, congenital or acquired esophageal stricture, esophageal duplication, achalasia	-Medical comorbidities -Medications -Summary of any corrective procedures and records if available.	Esophageal anomalies

		-Any other associated anomalies. -Summary of investigations (endoscopy, contrast studies) -Associated growth failure. -Complications of regurgitation.	
Post natal diagnosis of congenital pulmonary malformations	CPAM vs pulmonary sequestration	-Gestational age at birth -Medical comorbidities. -Any associated respiratory symptoms (distress, accessory muscle use, cough) -History of pulmonary infection -Results of CXR at birth. -Any additional cross-sectional imaging. -Family history of thyroid, brain, renal, ovarian, cervical, testicular or pleural cancers. -Prenatal investigations and results.	-Asymptomatic congenital pulmonary lesions usually require cross sectional imaging by CT at a pediatric institution by 3 months of age.
Skin lumps, soft tissue lesions	Common examples include: Dermoid cyst, pilomatrixoma, sebaceous cyst and lipoma.	-Medical comorbidities -Onset, interval growth, association with insect bites or trauma. -Associated symptoms such as inflammation, drainage, pain, activity limitations.	Please note that facial lesions should be referred to plastic surgery.
Chest wall deformities	-Pectus carinatum: sternum and ribs protrude forward. AKA “pigeon chest”. -Pectus excavatum: depression of the sternum + ribs	-Medical comorbidities (connective tissue disorders, cardiac anomalies and previous thoracic interventions) -Allergies, specifically to metal.	-Please note that most chest wall deformities will not be offered repair without the child’s expressed interest proceeding.

	producing a “funnel chest” appearance.	-Any previous cardiac or pulmonary function investigations. -Self-esteem concerns. -Degree of child’s interest in proceeding with repair.	-Repair is not usually considered prior to the onset of puberty.
Lymphatic malformations	Fluid filled cystic spaces caused by abnormal development of the lymphatic system that may be located along any of the body’s lymphatic channels.	-Medical comorbidities -History of bleeding or infection within the lymphatic malformation. -Associated symptoms such as pain or local compressive effects (ex. obstruction) -Imaging investigations.	-Please note that other vascular anomalies can be referred to the vascular malformations clinic.
Branchial anomaly	Congenital cysts, pits, nodules, dimples or sinus tracts commonly along the SCM related to the branchial remnants.	-Medical comorbidities -Associated symptoms (drainage, pain, infection) -Exacerbating factors for symptoms. -Any imaging investigations.	
Thyroglossal duct cyst	Midline neck mass in the region of the hyoid bone that moves with tongue protrusion.	-Medical comorbidities -Associated symptoms (drainage, pain, infection) -Any imaging investigations.	
Cervical adenopathy	Adenopathy with symptoms concerning for malignancy or any of the following red flags: ->2cm in size -No improvement or decrease after 4-6 weeks. -steady increase in size over 2-3 weeks -Hard, fixed, matted, non-tender. -Supraclavicular	-Medical comorbidities -CBC, LDH, CRP, ESR -Chest x-ray -Duration of mass and interval growth. -Symptoms/signs suggestive of malignancy (weight loss, night sweats, hepatosplenomegaly, pallor) -Associated fever lasting > 1 week -Immunization status -History of travel	Most cervical adenopathy patients can be referred to a pediatrician for further work up but if timely biopsy has been deemed necessary based on concerning features, this can also be facilitated by ENT.

		-Exposure to animals -Recent infections. -Antibiotic treatment and duration tried.	
Thyroid lesion	Concerning thyroid lesion on ultrasound or by exam ->Ti-RADS 3, 4 or 5 lesions or lesions causing compression to surrounding structures ->medically refractory inflammatory or hyperthyroid conditions ->genetic predisposition to thyroid cancer	- History and medical comorbidities - physical exam including lymphadenopathy if any - Imaging results - relevant laboratory investigations - signs and symptoms of hyper or hypothyroidism - Family history of thyroid cancer or predisposing conditions such as MEN2A or 2B, Cowden disease, FAP or Li Fraumeni syndrome	- Inflammatory or hyperthyroid conditions should be referred to CHEO endocrinology first to trial medical therapy. - referral to CHEO genetics is usually required to confirm genetic syndromes prior to surgical consultation - Some specific thyroid cancer causing mutations require thyroidectomy as early as 1 year of age
Breast lesion	Examples include: fibroadenoma, breast abscess, duct ectasia, breast cyst, nipple discharge.	-Medical comorbidities -Medication history (oral contraceptives) -Duration of mass and interval growth. -Menstrual history -Family history of breast malignancy -Duration and type of antibiotics if needed. -Color of nipple discharge if present -Associated symptoms such as pain or skin changes. -Results of imaging investigations.	Breast lesion
Prenatal Consult	Congenital anomaly detected prenatally in the thorax, abdomen or pelvis of a fetus.	-Maternal age -Maternal Medical comorbidities and medications. -Relevant maternal social history. -Suspected anomaly.	Prenatal Consult

		-Gestational age of the fetus and expected date of delivery -Results of amniocentesis, if performed. -Concerns for fetal or maternal complications (hydrops, polyhydramnios). -Results of all relevant prenatal US or MRI	
Solid Tumor	Common examples include: Neuroblastoma, Wilm's tumor, Rhabdomyosarcoma		Recommend referral to ER for urgent diagnostic work up.