Date:

Name of the requester:

Patient Family Member Physician/Provider

Name of the Patient:

Age:

City:

Province:

EB Type:

Question(s):

Primary Physician/Provider Name:

Contact Information

Phone:

Email:

CONSENT

For Patients Yes, I agree for you to contact my primary physician/provider

For Physicians/Providers Yes, I have the consent of the patient to discuss his/her care with you

Please email the completed form to **EB.advice@sickkids.ca**