CALGARY SKIN CANCER CENTRE

316 – 3320 17th Avenue SW Calgary AB
P: 403-700-0110 F: 403-700-0271

REFERRAL FORM

Date of Referral: _____ From: Dr._____

Patient Demographics (Please write or place patient label below)

Reason for Referral:

☐ **CONSULTATION** – Full Skin Review, Sun-Damaged Skin, Skin Cancer Screening (including patients with family history or risk factors for skin cancer)

☐ **BIOPSY** – Suspicious Mole(s)/Lesion(s)

☐ **WIDE LOCAL EXCISION** (Please attach relevant pathology report(s))

☐ **EXCISION** – Benign "Lumps & Bumps" (Ex. Lipoma, Cyst, Acrochordon, etc.)

☐ **MOHS MICROGRAPHIC SURGERY** (Please attach pathology report(s))

Relevant Medical History:

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Please FAX referrals to (403)700-0271

Referrals will be triaged daily and patients will be contacted within 7 business days of receipt of referral. If a more urgent assessment is required, please contact booking coordinator directly at: (403) 700-0110 ext. 2 or info@calgaryskincancer.com