CALGARY SKIN CANCER CENTRE

#316 – 3320 17TH AVE SW
CALGARY, AB T3E 0B4
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, Acrochordons, 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 14 business days of receipt of referral. If a more urgent assessment is required, or to request an e-consult, please contact surgical coordinator directly at: (403) 700-0110 ext. 5 or emma@calgaryskincancer.com

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HEAD & NECK SURGERY – FACIAL PLASTIC & RECONSTRUCTIVE SURGEON MOHS
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