SKIN DISORDERS CLINIC

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IMPORTANT INFORMATION:

Please ensure to provide the patient's email address and the provider billing number as well. Your patient will be scheduled at a location based on triage and geographic parameters.

SUGGESTED TIMEFRAME:

O URGENT O SEMI-URGENT O NON-URGENT

PHYSICIAN INFORMATION:

DATE:

Referrer: _____ Billing #: _____ Phone: _____ Fax: _____

Family Physician: _____ Phone: _____ Fax: _____

PATIENT DETAILS:

LAST Name: _____

FIRST Name: _____

Health Card #: _____ Gender: _____

Home: _____ DOB: _____

Cell: _____ Work: _____

EMAIL: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

If child, Parent Name(s): _____

PAST MEDICAL HISTORY: or attach CPP

_____

_____

MEDICATIONS: or attach CPP

_____

_____

ALLERGIES: or attach CPP

_____

_____

REASON FOR REFERRAL:

Please provide details below:

_____

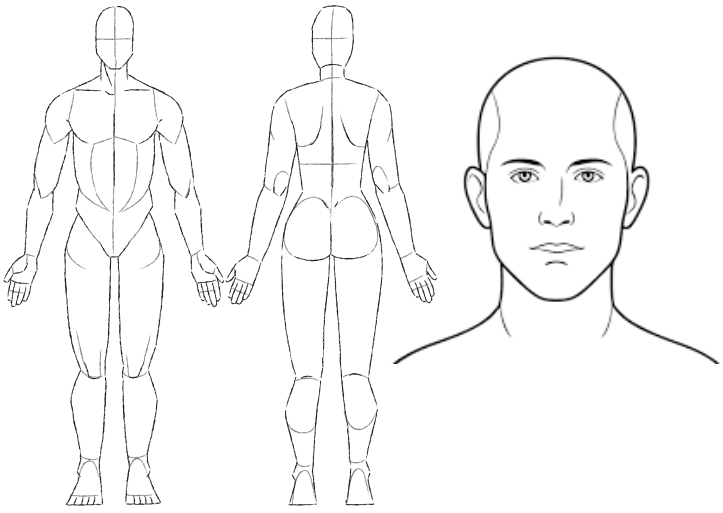
_____

_____

_____

_____

_____



DDX (Mandatory):

_____

_____

Do you think your patient will require one of the following?
O Biopsy/excision of a suspicious lesion
O Excision of gross residual disease after biopsy or recurrence (please attach pathology)