LAKEVIEW MEDICAL CLINIC
#5 3109 Palliser Drive SW, Calgary, Alberta
Tel: 403-242-4172 Fax: 403-242-4296

DERMATOLOGY CONSULT REQUEST

Your Clinic Phone: _____ FAX COMPLETE REQUEST TO: 403-242-4296

Your Clinic Fax: _____ Date: _____

PATIENT LABEL	REFERRING PROVIDER'S STAMP/DETAILS

Reason for consult: (Please check at least one of the following)

	Symptoms		**Examination**		**Biopsy**		**Specific Diagnosis**
	Rash		General Skin Exam		Mole		Eczema
	Warts		Mole Examination		Skin Lesion		Acne
	Changing Mole		Skin Lesion Exam		Lipoma		Psoriasis
	Nail Changes		Lumps/Bumps		Lumps/Bumps		Rosacea
	Others:		Others:		Others:		Others:

General Comments:

Thanks for your referral.

****Please mark urgent at the top of this referral if an urgent consultation is required.**

****Please call our office if you do not receive a confirmation of receipt of your consult request within 5 business days.**