The Ottawa Hospital | L'Hôpital d'Ottawa

RAPID ACCESS DERMATOLOGY REFERRAL FORM

NOTE: This clinic is designed to provide rapid access to dermatology to provide **diagnostic clarification** or **therapeutic advice** for **ONE complaint.** This clinic **WILL NOT PROVIDE FOLLOW-UP** FOR PATIENTS. In most cases, ongoing care will be directed to the patient's primary care physician. Appointments will be very short (5-10 minutes). Please advise your patient about these aspects of their appointment.

THIS FORM IS REQUIRED FOR THE RAPID ACCESS CLINIC
PLEASE COMPLETE AND FAX TO 613-761-4087

Date of Referral (YYYY/MM/DD): _____

PATIENT INFORMATION/STICKER

Last Name: _____ First Name: _____

OHIP #: _____ Version Code: _____ DOB (D/M/Y): _____

Sex: ☐ Male ☐ Female ☐

Address: _____ City: _____ Postal Code; _____

Phone #: _____ Email: _____

ASSESSMENT REQUESTED

REASON FOR VISIT:

Diagnostic Clarification ☐ Therapeutic Advice ☐

PRESUMED DIAGNOSIS - PLEASE CHECK ONLY ONE (Due to high demand, some conditions may not be seen in the clinic going forward such as Alopecia, Nail Problems, Warts, Scarring, Rosacea, Pigmentation Problems)

Acne ☐	Arthropod Bites ☐	Atypical Nevus ☐	Bacterial Infection ☐	Blisters/Bullae ☐
Drug Eruption ☐	Dermatitis/Eczema ☐	Fungal Infection ☐	Hidradenitis Suppurativa ☐	Hives/Urticaria ☐
Itch/Pruritis ☐	Melanoma ☐	Non-Melanoma Skin Cancer ☐	Psoriasis ☐	Vasculitis ☐
Viral Infection ☐	Other - Please specify:			

REFERRING PHYSICIAN INFORMATION

Name: _____ Billing #: _____

Phone: _____ Ext. _____ Fax #: _____

Address: _____

Referring Physician's Signature: _____

WE WILL CONTACT PATIENTS DIRECTLY WITH APPOINTMENT TIMES.

THANK YOU FOR YOUR INTEREST IN THE RAPID ACCESS DERMATOLOGY CLINIC.