Division of Dermatology
737 Parkdale ave. 4th floor
Ottawa, ON, K1Y4M9

Fax completed forms:
613-761-4087

Ottawa Skin of Colour Clinic

Referral Form

Date:_____

Referring Dermatologist Info/Label:

Referral date:_____

Referring MD:_____

Billing #:_____

Phone:_____

Fax:_____

Patient Info/Label:

Full name: _____

DOB (dd/mm/yyyy):_____

Gender:_____

OHIP number:_____

Address:_____

Phone:_____ Alt:_____

Fitzpatrick skin type (1-6): _____

Racial skin type: (please *specify*)

☐ Asian: _____

☐ Black: _____

☐ Hispanic: _____

☐ Indigenous: _____

☐ Mediterranean: _____

☐ Middle Eastern: _____

Reason for Referral (select one)

1. Pigment abnormality

☐ Post-inflammatory HYPERpigmentation

☐ Post-inflammatory HYPOpigmentation

☐ Vitiligo

☐ Melasma

2. Skin cancer:

☐ Suspected Melanoma:

☐ Other skin malignancy or pre-cancer

3. Scarring conditions:

☐ Hypertrophic/keloidal scar

☐ CCCA/Acne keloidalis/neutrophilic (*circle*)

☐ Pseudofolliculariś barbae

4. Benign lesions: *Non-OHIP services

☐ Seborrheic keratosis

☐ Dermatosis papulosis nigra

☐ Mole, Dermatofibroma

5. ☐ Other skin condition:

Brief clinical history: _____

_____

_____

Clinic address/stamp of referring MD: