



CANADIAN DERMATOLOGY CENTRE

1390 DON MILLS ROAD,
NORTH YORK,
ON, M3B 0A7

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FAX: 416-840-3606
EMAIL: INFO@CANADIANDERMATOLOGY.COM

REFERRAL FORM

SPECIALTY

DERMATOLOGY PLASTIC SURGERY

TIME FRAME AND/OR TYPE

URGENT SEMI-URGENT ROUTINE

PATIENT INFORMATION:

PATIENT NAME:	GENDER:	DOB: (MM/DD/YYYY)
ADDRESS:	CITY:	POSTAL CODE:
HOME PHONE #:	CELL PHONE #:	EMAIL:
HEALTH CARD (VC):		

REASON FOR REFERRAL (DIAGNOSIS AND/OR CHIEF COMPLAINT):

Dermatological Conditions	Plastic Surgery Conditions
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Skin Cancer (BCC/SCC)
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Melanoma
<input type="checkbox"/> Acne	<input type="checkbox"/> Non-Infected Cyst
<input type="checkbox"/> Skin Cancer/Lesion	<input type="checkbox"/> Benign Lesions
<input type="checkbox"/> Skin Checks	<input type="checkbox"/> Ganglions

PERTINENT CLINICAL INFORMATION:

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REFERRING PROVIDER:

NAME:	PHONE #:	Office Stamp
ADDRESS:	FAX #:	
BILLING NUMBER:	SIGNATURE:	