

Fax completed forms:
613-761-4087

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*)

☐ Pseudofollicularis barbae

4. Benign lesions: *Non-OHIP services

☐ Seborrheic keratosis

☐ Dermatoses papulosis nigra

☐ Mole, Dermatofibroma

5. ☐ Other skin condition:

Brief clinical history: _____

Clinic address/stamp of referring MD: