Rapid Access Skin Cancer Clinic Referral

DERMATOLOGY + AESTHETICS CENTRE

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Email: info@qderm.ca
www.qderm.ca

PATIENT INFORMATION:

Name Or Label: _____

PHN: _____

☐ Male ☐ Female ☐ Other: _____

DOB (dd/mm/yy): _____

Address: _____

City: _____

Postal code: _____

Cell# (or Home#): _____

Email: _____

An e-mail address is required as the majority of our communication is done via this method.

Date: _____

REFERRING PROVIDER:

☐ Primary Care Provider
☐ Specialist
☐ Urgent Care/Walk-In
☐ Nurse Practitioner/RN

Name: _____

MSP #: _____

Phone#: _____

Fax#: _____

REASON FOR REFERRAL

Patients should be made aware that their referral will be triaged to one of our dermatologists or dermatology-focused general practitioners based on availability. If a patient sees a dermatology-focusedgeneral practitioner, they may be internally re-referred to a dermatologist if necessary.

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NOTE (i.e. location, duration, treatments attempted and personal and/or family history of skin cancer)

Please include relevant medical history, medication records, investigations, and labs.
See Attached:

☐ Consult notes ☐ Medication lists ☐ Lab Results ☐ Allergies