

Referral Form



DERMATOLOGY +
AESTHETICS CENTRE

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.

Fax: 604-734-4887

Telephone: 604-359-9632

Address: A600 20020 84 Ave, Langley, BC V2Y 5K8

Email: info@qderm.ca

www.qderm.ca

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-focused general practitioner, they may be internally re-referred to a dermatologist if necessary.

- Skin Cancer Screening / Mole Check
- Concerning Lesion (eg, SCC, BCC, Melanoma)
- Acne
- Rosacea
- Eczema
- Psoriasis
- Phototherapy
- Elective lesion removal (ie, Skin Tags, Seborrheic Keratoses, Cyst) Patient aware this is not MSP covered
- Other or more history:

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

- Consult notes
- Medication lists
- Lab Results
- Allergies