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www.centrefordermatology.com

Date: _____

Referring Physician: _____ OHIP Billing # _____

Patient Information or LARGE FONT label

Name: _____ DOB: _____
(dd/mm/yy)
Health Card: _____ Version: _____
Address: _____
Phone number: _____

Reason for consultation:

- | | |
|--|--|
| <input type="checkbox"/> General Dermatology | <input type="checkbox"/> URGENT Care Clinic |
| <input type="checkbox"/> Phototherapy and Psoriasis Centre | <input type="checkbox"/> Wart clinic |
| <input type="checkbox"/> Non-melanoma skin Cancer Clinic | <input type="checkbox"/> Melanoma/ Pigmented Lesion Clinic |
| <input type="checkbox"/> Contact dermatitis/ Patch Test Clinic | <input type="checkbox"/> Clinical Trials Research Centre |
| <input type="checkbox"/> SKiN Laser Clinic (referral not required; 705.775.3223) | |

Please provide history along with relevant lab results and please attach patient profile:

Please fax request to 705.775.DERM (3376)
Your office will be contacted by fax with an appointment