SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: ____________________ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* ____________________

DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male

OHIP #: ____________________ Version Code: ____________________

Account #: ____________________ Date of Admission: dd / mm / yy

Diagnostic – Fax: (905) 952-2819

Skin Cancer Diagnostic Assessment Clinic - Physician Referral

Name: ____________________

Patient Address: # Street Town Province Postal Code

Patient Preferred Phone Number: ____________________ **Patient Alternate Phone Number:** ____________________

Primary Care Practitioner Name: *(print last,first)* ____________________

Primary Care Practitioner Phone Number: ____________________ **Fax Number:** ____________________

MEDICAL HISTORY:

Medications: *Please hold the following for 5-days prior to procedure:* ❑ ASA ❑ Anticoagulants ❑ Antiplatelet Agents

Other Medications:

Allergies:

Significant Medical & Previous Medical History: ____________________

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Site of Lesion:

History of Lesion:

PLEASE INCLUDE ANY PREVIOUS BIOPSY RESULTS OR TREATMENT RECORDS (IF A RECURRENCE)

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* ____________________ **Billing #:** ____________________

Referring Physician Signature: ____________________ **Date:** dd / mm / yy

Phone Number: ____________________ **Fax Number:** ____________________

CLINIC USE ONLY

Date Received: dd / mm / yy **Appointment Date:** dd / mm / yy **and Time:** __________

S-SKICDACPR