

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: _____ Health Card Number _____
 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: _____

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: _____

