

**NOTE: Email is mandatory for all patient communications**

**PHYSICIAN INFORMATION:**

**DATE:**

Referrer: \_\_\_\_\_ Billing #: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT DETAILS:**

LAST Name: \_\_\_\_\_

FIRST Name: \_\_\_\_\_

Health Card #: \_\_\_\_\_ Gender: \_\_\_\_\_

EMAIL: \_\_\_\_\_

Home: \_\_\_\_\_ DOB: \_\_\_\_\_

Cell: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

If <16, Guardian Name(s): \_\_\_\_\_

**REASON FOR REFERRAL:**

Please provide details below:

- Severe Acne, requesting oral isotretinoin
- Lesion of Concern
- Psoriasis
- Eczema
- Other, please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY:** or attach CPP

\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS:** or attach CPP

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES:** or attach CPP

\_\_\_\_\_

**\*\*We do not accept referrals for warts, nail concerns or infected cysts.**

**\*\*If the concern is cosmetic, please have patient self-refer to PureSkin Dermatology - 519-432-6556 or www.pureskin.ca**