



PATIENT INFORMATION:

Name _____
Or _____
Label: _____

PHN: _____ Male
DOB (dd/mmm/yy): _____ Female
Address: _____ Other _____
City: _____ Postal code: _____
Email: _____
Cell# (or Home#): _____

DATE: _____

REFERRING PROVIDER:

- Primary Care Provider
- Emergency Dept./
- Urgent Care/Walk-In
- Specialist: _____
- Nurse Practitioner/RN

Name: _____
MSP #: _____
Phone#: _____
Fax#: _____

REASON FOR REFERRAL

Please select: ROUTINE **Urgent**

- Psoriasis, Eczema, or Dermatitis NYD x _____ weeks/months/years
- Complex Dermatological or Long-term management (attach relevant notes/letters)
- Pigmented Lesion/Rule out Melanoma/Skin Cancer
- Hair or Nail Related
- Phototherapy (Narrow-band UVB; please circle: Psoriasis / Eczema / Vitiligo) Hand/Foot UVB
- Systemic disease (SLE, RA, Diabetes, Hypothyroidism, etc.) with cutaneous manifestations
- Skin Cancer Screening (Transplant population, or history of SCC, BCC, Melanoma)
- Elective Excision of Benign lesion, i.e., seborrheic keratosis (patient aware this is not MSP covered)
- Acne/Rosacea

Other:

Please include recent relevant medical history, medication records, investigations and lab results. **SEE ATTACHED:** CONSULT NOTES MEDICATION LIST
 LAB RESULTS ALLERGIES

Fax: **778-699-4548**
Telephone: **778-760-9977**
Address: 622-525 Highway 97 S, West Kelowna, BC, V1Z 4C9
Website: **www.OkanaganDerm.ca**