DATE: ______________________

PATIENT INFORMATION:

Name Or Label: [ ]

PHN: ______________________ ☐ Male

DOB (dd/mmm/yy): ______________________ ☐ Female

Address: ______________________ ☐ Other _____

City: ______________ Postal code: ________

Email: ______________________

Cell# (or Home#): ______________________

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/pathology)
☐ Pigmented Lesion/Rule out Melanoma/Skin Cancer
☐ Hair or Nail Related
☐ Phototherapy (Narrow-band UVB) ☐ 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 or More History:

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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**