FCP | DERMATOLOGY

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CONSULTATION REFERRAL FORM

☐ **Urgent**

BOARD-CERTIFIED DERMATOLOGIST

☐ **First available** ☐ **Dr. Jane Wu** ☐ **Dr. Kristy Bailey** ☐ **Dr. Trevor Champagne**

PATIENT INFORMATION		
Name		label
Date of Birth		
Health Card		
Address		
Phone number	*Preferred*:	
	Alternate:	
Email		

PHYSICIAN INFORMATION		
Referring MD		label/stamp
OHIP Billing #		
Office phone		
Office Fax		
Family MD		

REASON FOR REFERRAL		
Relevant History	*Please check where applicable:*	
	☐ Melanoma	☐ Pigmentation
	☐ Other skin cancer	☐ Warts
	☐ Mole check	☐ Hair loss
	☐ Acne/rosacea	☐ Skin tags
	☐ Psoriasis	☐ Hyperhidrosis
	☐ Eczema	☐ Cosmetic
	☐ Vitiligo	☐ Other

Physician Signature______________________ **Date**___________________

Office Use Only Date Received: Date Booked: Patient Notified: