SKIN CARE WEST

MEDICAL + SURGICAL DERMATOLOGY

302-6545 PORTSMOUTH ROAD, NANAIMO, BC V9V 1A3 | **T:** 250-740-2125 | **F:** 250-244-4769 | **SKINCAREWEST.COM**

DATE OF REFERRAL: *(MM/DD/YYYY)*

☐ ROUTINE ☐ SEMI-URGENT *(3 MONTHS)* ☐ URGENT *(4 WEEKS)*

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
LAST NAME:	NAME:
FIRST NAME:	MSP #: LOCUM: ☐ YES ☐ NO
PHN: *(PUBLIC HEALTH NUMBER)*	**CLINIC NAME:**
DOB: *(MM/DD/YYYY)*	STREET ADDRESS:
GENDER: ☐ MALE ☐ FEMALE ☐ *OTHER:* ________	PHONE:
STREET ADDRESS:	FAX:
	PRIMARY CARE PROVIDER INFORMATION ☐ *SAME AS REFERRING*
HOME PHONE:	NAME:
CELL PHONE:	
EMAIL: *(REQUIRED)*	**WAS PATIENT ASSESSED VIRTUALLY?** ☐ YES ☐ NO

**** We will acknowledge receipt of referral by **fax**. We will inform patient of appointment by **email**. ****

REASON FOR REFERRAL: (Determines appropriate physician. Returning patients usually booked with previous provider.)

NEW BIOPSY CONFIRMED INVASIVE MELANOMA
Referred to another provider for wide lesion excision?
☐ YES ☐ NO

BENIGN LESIONS/COSMETIC CONCERNS
Referrals accepted if diagnosis or management uncertain. Otherwise, direct patient to our website for more information on private booking.

PERTINENT MEDICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES:

******PLEASE ATTACH RELEVANT PATHOLOGY REPORTS AND LABORATORY STUDIES*****