



WOMEN'S COLLEGE HOSPITAL
 Health care for women | REVOLUTIONIZED

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REFERRAL FORM

R.K. SCHACHTER DERMATOLOGY

Referral Date: ____ / ____ / ____
 YYYY / MM / DD

PATIENT INFORMATION
 (Affix Patient Label/Identification Here)

Name: _____ DOB: ____ / ____ / ____
 YYYY/MM/DD

Health card: _____ Version code: _____

Full address: _____

Telephone: _____ Alternate #: _____

ADDITIONAL PATIENT INFORMATION

Other insurance coverage (IFH, UHIP, etc.) Self-Pay

Language spoken: _____ Interpreter required: Yes No

Allergies: _____ Gender: _____

REFERRING PROVIDER INFORMATION

Name: _____
 Address: _____ Billing #: _____
 Telephone: _____ Signature: _____
 Fax: _____

Alternate report sent to: _____ (name/contact information)

REASON FOR REFERRAL

Diagnosis and/or chief complaint:

CLINICAL INFORMATION /FINDINGS

Past and current medical history: (Include cumulative patient profile, if available)

Please include all relevant investigations/results for the patient including: blood work (CBC), pathology reports, consults

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