WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

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Toronto, Ontario
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PATIENT INFORMATION
(Affix Patient Label/Identification Here)

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

Health card: _____ Version code: _____

Full address: _____

Telephone: _____ Alternate #: _____

REFERRAL FORM

❑ R.K. SCHACHTER DERMATOLOGY

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

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:

Fax: Signature: _____

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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