WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
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**Tel: 416-323-7546 Fax: 416-323-6236**

# RKS DERMATOLOGY REFERRAL FORM

**URGENCY:** ❑ Routine ❑ Semi-Urgent ❑ Urgent

**REFERRAL DATE:** ____/____/_____
DD / MM / YYYY

**PATIENT INFORMATION**
*(Affix Patient Label/Identification Here)*

MRN:_____ HCN:_____

Name:_____

Sex:_____ Date of Birth:____/____/_____
DD / MM / YYYY

Address:_____

Telephone:_____ Alternate #:_____

**SPECIFIC PHYSICIAN:** ☐ No (First available) ☐ Yes: Dr. _____

## ADDITIONAL PATIENT INFORMATION

Preferred name: Gender (*if not same as above*):

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ _____

Other insurance coverage (IFH, UHIP, etc.): ☐ Self-pay

Language spoken: Interpreter required: ☐ Yes ☐ No

## REFERRING PROVIDER INFORMATION

Name:

Address:

Telephone:

Fax:

Billing #: _____

Signature: _____

☐ Referring Provider is not the Primary Care Provider
Primary Care Provider Name: _____ Phone:_____ Fax:_____

## REASON FOR REFERRAL

Has the patient previously seen a Dermatologist for this issue? ☐ No ☐ Yes

**Please attach all relevant results/reports:**

☐ Bloodwork (CBC)

☐ Pathology reports

☐ Consultation reports

## ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):