



WOMEN'S COLLEGE HOSPITAL 76 Grenville Street
Toronto, Ontario
Healthcare | REVOLUTIONIZED M5S 1B2

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: _____ Billing #: _____

Address: _____ Signature: _____

Telephone: _____

Fax: _____

☐ 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? <input type="checkbox"/> No <input type="checkbox"/> Yes | Please attach all relevant results/reports: |
| | <input type="checkbox"/> Bloodwork (CBC) <input type="checkbox"/> Pathology reports <input type="checkbox"/> Consultation reports |

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):

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