Note: As PERC is a tertiary care centre, the patient will be returned to your care for follow up once treatment is completed. A 6-month light break is necessary before re-referring.

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

☐ Psoriasis: Reason for referral:

Body Surface Area (BSA) ______________________________

Dermatology Life Quality Index (DLQI) ______________________________

☐ Cutaneous T-Cell Lymphoma (CTCL) / Mycosis Fungoides (MF) (biopsy required)

Please confirm:

☐ patient is ambulatory/can stand for at least 5 mins

☐ patient can attend treatment 3 times/week for 8 weeks

☐ Other: ______________________________ (biopsy required)

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):