



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

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PHOTOTHERAPY EDUCATION & RESEARCH CENTRE (PERC) 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 #: _____

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:
Body Surface Area (BSA) _____
Dermatology Life Quality Index (DLQI) _____

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

☐ Other: _____ (biopsy required)

Reason for referral:

Please confirm:

- ☐ patient is ambulatory/can stand for at least 5 mins
☐ patient can attend treatment 3 times/week for 8 weeks

ADDITIONAL CLINICAL INFORMATION

Past and current medical history:

Allergies and reaction:

Current medications (include list):

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