WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street
Toronto, Ontario
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:

Address:

Telephone:

Fax:

Billing #: _____

Signature: _____

❑ 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):