

Please note: OHIP only covers the cost of the initial consultation. Wait time 3-4 weeks.
There will be a charge for radiographs, future appointments and most additional procedures.
Payment is due at time of service. Assignment from insurance companies is not accepted.

PLEASE PRINT CLEARLY. INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED

Patient Information: Male Female Date of Birth: _____ / _____ / _____
Year / Month / Day

Print name exactly as on Health Card

Name: _____
Surname First name

Health Card #: _____ version code

Address: _____ Phone: H: _____
City Postal Code B: _____
C: _____

Referred to:

1st available pathologist Dr. Grace Bradley Dr. Hagen Klieb Dr. Marco Magalhaes

Reason for Referral:

Other information:

Location of lesion: _____
Size: _____ Shape: _____
Color: _____ Ulceration: Yes No
Pain: Yes No
When Lesion First Noticed: _____

Has the patient had a biopsy of this lesion in the past?
No Yes (enclose results)

Medical History:

Medications:
Allergies:

Referring Practitioner Information:

Physician: _____ Dentist: _____ Specialty if applicable: _____ OHIP Billing Number: _____
Name: _____
Address: _____
Telephone: _____ Fax: _____

For office use only: Date received: _____ Triaged by: _____ Priority: _____
Referral accepted _____ Not accepted: Returned for more info Redirected
Date and time of appointment: _____ Notification: Patient Referring doctor
Appointment with: _____
Hospital file number: _____ Account number: _____