Sunnybrook Dermatology FAX: 416-480-6897

(please fill out form completely)

FROM: **Dr.** _____ **BILLING: #** _____ **(mandatory)**

ADDRESS: _____

Telephone # _____ **Fax #** _____ **(mandatory)**

Referring physician's signature:
(must be signed) _____

PHYSICIAN REQUESTED (please check):
(note: due to triage needs and area of expertise we may not be able to honour specific requests)

□ **ALHUSAYEN**	□ **BOBOTSIS**	□ **CYRENNE**	□ **DEKOVEN**
□ **LANSANG**	□ **MUFTI**	□ **PON**	□ **SANDRE**
□ **SHAPIRO**	□ **TRAN**	□ **WALSH**	□ **YEUNG**
□ **BARGMAN**(laser)	□ **LASER**		

PATIENT INFORMATION:

LAST NAME: _____ **FIRST NAME:** _____

FULL ADDRESS: _____

PHONE # HOME: _____ **CELL:** _____

EMAIL: _____ **OHIP #** _____ **DOB:** _____

Reason for Referral:

in accordance with CPSO guidelines , your referral must include the following information:

- □ **History of presenting problem**
- □ **Patient's medical history and Medication list**
- □ **Results of relevant tests and procedures**
- □ **Previous consultation reports**

Is this for a 2nd opinion? □ **YES** □ **NO**

Family Dr name: _____ □ **Same as referring Dr**

~~Revised 2/2025~~