

# Sunnybrook Dermatology FAX: 416-480-6897

(please fill out form completely)

FROM: Dr. \_\_\_\_\_ BILLING: # \_\_\_\_\_  
(mandatory)

ADDRESS: \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

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)

- |                                    |                                  |  |                                  |
|------------------------------------|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> ALHUSAYEN | <input type="checkbox"/> ASSAAD  | <input type="checkbox"/> BARGMAN (laser) | <input type="checkbox"/> CHEN    |
| <input type="checkbox"/> DEKOVEN   | <input type="checkbox"/> LANSANG | <input type="checkbox"/> PON             | <input type="checkbox"/> SHAPIRO |
| <input type="checkbox"/> SHEAR     | <input type="checkbox"/> TRAN    | <input type="checkbox"/> WALSH           | <input type="checkbox"/> YEUNG   |
| <input type="checkbox"/> LASER     |                                  |  |                                  |

## PATIENT INFORMATION:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

FULL ADDRESS: \_\_\_\_\_

PHONE # HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

EMAIL: \_\_\_\_\_ OHIP # \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Referral:

in accordance with CPSO guidelines , your referral should 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