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)

□ ALHUSAYEN	□ ASSAAD	□ BARGMAN (laser)	□ CHEN
□ DEKOVEN	□ LANSANG	□ PON	□ SHAPIRO
□ CHAMPAGNE	□ TRAN	□ WALSH	□ YEUNG
□ 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**

Revised 2/2020