# PATCH TESTING CONSULTATIVE CLINIC REFERRAL FORM

(please fill out completely and fax to 416-480-6897)

Our dermatologists will provide initial consultation, patch test reading, and appropriate counselling. A report of any positive allergens will be **sent back to the referring physician for ongoing management**.

**Please inform your patients that patch testing will **NOT** be completed the same day as the initial consultation.**

**Patient Information:**

LAST NAME: FIRST NAME:
D.O.B.: PATIENT OHIP # VERSION CODE:
ADDRESS:
PHONE # :

**Referring Physician**

FROM: Dr. ______________________________ Billing#: ______________ (Mandatory)
Address: ______________________________ Telephone:__________________
______________________________ Fax: _______________________

*Physician signature: ________________________ (Must be signed) Date: ____________

***By signing this referral, I understand that the patch test clinic at Sunnybrook Dermatology is a consultative clinic that does not provide long term follow-up care for my patient. I agree to see my patient for further discussion and ongoing management as necessary.**

Reason for patch test request:

Patient occupation and suspected allergens/exposures:

Has patient had patch testing in the past: Yes: ☐ No: ☐
If yes, when:
Positive allergens:

Systemic medications for skin or immunosuppressive agents for other reasons? Yes: ☐ No: ☐
If yes, list dosages: