(PLEASE FILL OUT COMPLETELY)

FAX REFERRAL FORM FOR PATCH TESTING

(please fax to Sunnybrook Dermatology at (416) 480-6897)

TO: **Sunnybrook Dermatology** **FAX: 416-480-6897**
PATCH TEST CLINIC

FROM: **Dr.____________________** **BILLING#: ____________** **(Mandatory)**
MAILING ADDRESS:

Physicians signature:_________________________________ **(Must be signed)**

Patient Information for Referral to Patch Test Clinic

LAST NAME: **FIRST NAME:**
ADDRESS:

POSTAL CODE:

PHONE # - HOME: **WORK:**

PATIENT OHIP # **VERSION:** **D.O.B.:**

PATIENT COMPLAINT:

RELIVANT HISTORY (MUST BE FILLED OUT):

DATE OF PREVIOUS PATCH TESTING: