*(PLEASE FILL OUT COMPLETELY)*

# FAX REFERRAL FORM

**TO:** **Sunnybrook Dermatology** **FAX: 416-480-6897**

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

**Referring Physician's signature:**

***(Must be signed)***

**PHYSICIAN (please check) :**
**(Note: due to triage needs and areas of expertise, we may not be able to honour specific requests)**

□ Shear □ DeKoven □ Assaad □ Walsh
□ Lansang □ Pon □ Shapiro □ Yeung
□ Laser □ Cosmetic Cover-up □ Drug Reaction Clinic

**Please provide details to help us triage your patient:**

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

**PATIENT ADDRESS:**

**POSTAL CODE**

**PATIENT PHONE # - HOME:** **WORK:**

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

**PATIENT COMPLAINT (please check):**

□ Acne □ Alopecia Areata □ Cosmetic Camouflage
□ Dermatitis □ Drug Rash □ Leg Ulcers
□ Psoriasis □ Possible Melanoma □ Rosacea
□ Skin Cancer (BCC, SCC, MF) □ Vitiligo
□ Other: