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| Please **FAX** form and documents to New Patient’s Booking Office (416)480-6179  **Date of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Purpose: To expedite biopsy of skin lesions that appear highly suspicious for melanoma**  **All patients referred to the melanoma expedited assessment clinic will be assessed by a dermatologist AND a surgeon and may have a biopsy on the same day.** | | |
| **Suspected unbiopsied melanoma:**  🞎 Bleeding lesion  🞎 Lesion > 6mm in size  🞎 Lesion multi-coloured or significant change in colour  🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anticoagulant use 🞎 Yes 🞎 No  Has the patient been informed of referral to expedited assessment clinic? **□ Yes □ No** | | **Location**  **□** Extremity  **□** Trunk  **□** Head & Neck |
| **Communication of Results and Subsequent Care:**  Patient diagnosis communicated by, and subsequent care managed by the **1st available Sunnybrook Melanoma Surgeon or Dermatologist. If the biopsy is negative for melanoma, the patient’s care will be returned to the referring MD, or referred to an appropriate specialist.** | | |
| **PATIENT INFORMATION** | | |
| Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  OHIP#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version Code:\_\_\_\_\_\_ DOB(*D/M/Y*):\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_  Sex: M / F Does patient speak English? □Yes □No (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_  Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business/Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **DOCTOR INFORMATION** | | |
| Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Billing #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Phone*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_\_\_\_\_\_\_ *Secure Fax #*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Supporting Documentation:**  Referral Letter H & P □ | Referring Physician’s Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **OCC OFFICE USE ONLY** | | **OCC Reference:** |  | **SHSC Reference:** |  |
| **Clinic Booked:** |  | **Date Booked:** |  | **Time Booked:** |  |
| **Clinic Return:** |  | **Date Booked** |  | **Time Booked** |  |
| **Clinic appointment called to:** | | **Referring Physician** | | **Patient** | |