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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** |