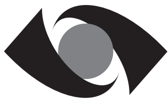

SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Diagnostic – Fax: (905) 952-2819

Health Record #: ____________ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* ____________
DOB: dd / mm / yy  Age: ______  ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Account #: ____________ Date of Admission: dd / mm / yy

# *Skin Cancer Diagnostic Assessment Clinic - Physician Referral*

**Name:** ____________

**Patient Address:** # Street Town Province Postal Code

**Patient Preferred Phone Number:** ____________ **Patient Alternate Phone Number:** ____________

**Primary Care Practitioner Name:** *(print last,first)* ____________

**Primary Care Practitioner Phone Number:** ____________ **Fax Number:** ____________

**MEDICAL HISTORY:**

**Medications:** *Please hold the following for 5-days prior to procedure:* ❑ ASA ❑ Anticoagulants ❑ Antiplatelet Agents

**Other Medications:**

**Allergies:**

**Significant Medical & Previous Medical History:** ____________

____________

**Site of Lesion:**

**History of Lesion:**

**PLEASE INCLUDE ANY PREVIOUS BIOPSY RESULTS OR TREATMENT RECORDS (IF A RECURRENCE)**

**BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL**

**Referring Physician Name:** *(print first, last)* ____________ **Billing #:** ____________

**Referring Physician Signature:** ____________ **Date:** dd / mm / yy

**Phone Number:** ____________ **Fax Number:** ____________

**CLINIC USE ONLY**

**Date Received:** dd / mm / yy **Appointment Date:** dd / mm / yy **and Time:** ____________