Date: _____

SKIN PHYSICIANS
MEDICAL · COSMETIC · LASER

DERMATOLOGY REFERRAL FORM

CONSULTANT : Dr. Neel Malhotra MD, FRCP(C)

PATIENT INFORMATION

Patient's Name:	Gender: ☐ Male ☐ Female ☐
Date of Birth:	PHN:
Address:	
City & Province:	Postal Code:
Home Tel:	Work Tel:

REASON FOR REFERRAL: ☐ Routine ☐ Urgent

RELEVANT MEDICAL HISTORY & MEDICATIONS: ☐ Chart Attached

REFERRING PHYSICIAN

Physician's Name:	PRACID:
Work Tel:	Work Fax:
Signature:	

Please Fax to 587.520.3283 Thank you!

WWW.SKINPHYSICIANS.CA

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