Hôpital Régional de Pembroke Regional Hospital

STORE AND FORWARD DERMATOLOGY REFERRAL FORM

Fax completed forms to: 613-732-6350

*****Incomplete forms will be returned*****

*****Please attach all relevant consults, imaging and bloodwork*****

Patient Information or Label:	***Referring MD Information or Label:***
Patient Name: _____ DOB: _____	Referral Date: _____
Health Card #: _____	Referring MD: _____
Address: _____	CPSO Billing #: _____
_____	Phone: _____
Phone: _____ Alt: _____	Fax: _____

Reason for referral:

_____

_____

Significant Medical History:

_____

_____

Has this patient been previously assessed by a Dermatologist? NO ☐ YES ☐ (attach latest report)

Duration of disease:

Allergies:

Attempted Treatments – Topical & Systemic:

Current Medications: