REJUVENATION

Excellence In Skin Care Since 1984

Contact Information

P:778.800.2007
F:778.897.0688
Burnaby
3185 Willingdon Green
#100 Burnaby, BC,
V5G 4P3

Dermatology Consult Referral Form

Fax to:778.897.0688

Option 1

Appleseed, John
ID: 12345678
102, 10201 Southport Rd SW
Calgary, AB T2W 4X9
403-286-6888

Chart:
Gender: M
DOB: 01-JAN-1990

Apply Label Here

Urgency:

☐ Routine

☐ **Urgent** (Please provide reason under "Additional Information")

Option 2 - Leave blank if above complete

Patient and Physician Information:

Patient Last Name:_____ Given Name(s):_____

Address:_____ City:_____ Postal Code:_____

Phone Number:_____ PHN:_____ DOB:_____

Referring Physician:_____ Practice Phone Number:_____

Provider MSP:_____ Practice Fax Number:_____

Provider address:_____

Reason for Referral:

Consultation request will not be considered unless all required information is submitted and complete

Surgical & Medical Dermatology

☐ **Growth/Tumor/Lesion**
- Location:_____
- Duration:_____
- Tumour size:_____
- Biopsy done (please attach pathology): Yes ☐ No ☐
- Concern of basal cell carcinoma: Yes ☐ No ☐
- Concern of squamous cell carcinoma: Yes ☐ No ☐
- Concern of melanoma: Yes ☐ No ☐
- Concern of other: Yes ☐ No ☐
- Please specify:_____

☐ **Melanoma** (please attach pathology)

☐ **Photodynamic Therapy** Location:_____

☐ **Benign lesion** Location:_____ Size:_____

☐ **Rash**
- Location:_____
- Duration:_____
- Working Diagnosis:_____

☐ **Autoimmune diseases** (diagnosis)_____

☐ **Eczema** ☐ **Psoriasis**

☐ **Hair disease** ☐ **Nail Disease**

☐ **Hidradenitis suppurativa**

☐ **Skin check**

☐ **Other:**_____

Elective Dermatology

☐ **UV Therapy**
- Location:_____
- Eczema ☐ Severity:_____
- Psoriasis ☐ Severity:_____
- Other ☐ Severity:_____

☐ **Pigmented Lesions**

☐ **Vascular Lesions**

☐ **Acne & Scarring**

☐ **Skin Tightening**

☐ **Body Contouring**

☐ **Rosacea**

☐ **Melasma**

☐ **CO2 Laser Treatments**

☐ **Wart Treatments**

☐ **Cyst Removal**

Additional Information

Revised: June 2023