140 OXFORD STREET EAST
SUITE 207
LONDON ON N6A 5R9

WWW.LOVEDERM.CA

Psoriasis / Atopic Dermatitis Fast-Track Referral Form

REFERRING PHYSICIAN'S NAME: ______________________________

OHIP BILLING #: ______________________________

PHYSICIAN PHONE #: ______________________________

PHYSICIAN FAX #: ______________________________

PATIENT INFORMATION

NAME: ______________________________ DOB (MM/DD/YYYY): ______________________________

HEALTH CARD #: ______________________________ VERSION CODE: ______________________________

ADDRESS: ____

HOME PHONE #: ______________________________ CELL PHONE #: ______________________________

EMAIL ADDRESS: ______________________________

REASON FOR CONSULTATION:

- ☐ ATOPIC DERMATITIS (ECZEMA)
- ☐ PSORIASIS

AREAS INVOLVED:

- ☐ MORE THAN 10% BODY SURFACE AREA
- ☐ FACE
- ☐ HANDS
- ☐ FEET
- ☐ GENITALS

PREVIOUS TREATMENTS:

- ☐ TOPICAL STEROIDS – PLEASE LIST: ____
- ☐ ELIDEL
- ☐ PROTOPIC
- ☐ PHOTOTHERAPY
- ☐ SYSTEMIC AGENTS (E.G. BIOLOGICS) – PLEASE LIST: ______________________________

PATIENT MEDICAL HISTORY AND ANY ADDITIONAL INFORMATION:

PLEASE ATTACH ANY RELEVANT SPECIALIST CONSULTATION NOTES OR BIOPSY RESULTS

FAX TO: 519-438-2400