LOVEGROVE DERMATOLOGY

140 OXFORD STREET EAST
SUITE 207
LONDON ON N6A 5R9

WWW.LOVEDERM.CA

REQUEST FOR DERMATOLOGY CONSULTATION

PLEASE COMPLETE ALL SECTIONS LEGIBLY

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:

PATIENT HISTORY – Please include medications and attach relevant lab/biopsy results

FAX TO 519-438-2400