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DR. TANIA BHANJI
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NOTE: Email is mandatory for all patient communications

PHYSICIAN INFORMATION:

DATE:

Referrer: _____ Billing #: _____ Phone: _____ Fax: _____

Family Physician: _____ Phone: _____ Fax: _____

PATIENT DETAILS:

LAST Name: _____

FIRST Name: _____

Health Card #: _____ Gender: _____

EMAIL: _____

Home: _____ DOB: _____

Cell: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

If <16, Guardian Name(s): _____

REASON FOR REFERRAL:

Please provide details below:

- Severe Acne, requesting oral isotretinoin
- Lesion of Concern
- Psoriasis
- Eczema
- Other, please describe:

PAST MEDICAL HISTORY: or attach CPP

MEDICATIONS: or attach CPP

ALLERGIES: or attach CPP

****We do not accept referrals for warts, nail concerns or infected cysts.**

****If the concern is cosmetic, please have patient self-refer to PureSkin Dermatology - 519-432-6556 or www.pureskin.ca**