pureskin
DERMATOLOGY

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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
- ☐ Rosacea
- ☐ Lesion of concern, please describe

_____

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_____

PAST MEDICAL HISTORY: or attach CPP

_____

_____

MEDICATIONS: or attach CPP

_____

_____

ALLERGIES: or attach CPP

_____

**Mole Mapping & Skin Surveillance can be booked directly on our website at www.pureskin.ca

**Cosmetic requests are a non-OHIP covered consultation, please have patient self-refer: 519-432-6556 or www.pureskin.ca