Mercer Dermatology

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Referral Form:

Please Print Clearly or Pace Label

Date of Referral: ______________________________

Referring Physician: ______________________________

Physician Phone #: ____________________ Fax #: ____________________

Patient's Name: ______________________________

MCP # (or Health Card #): ______________________________

Date of Birth:____________________ Age: ____________

Patient's Address: ______________________________

Patient's Phone #: ______________________________

☐ Routine

*__Note:__ For all semi-urgent case requests, please call our clinic to speak directly with our triage nurse.

Requesting an opinion (i.e. a consultation) for: (check and/or circle most relevant)

Skin growth: (please provide the specific **location** on the body)

- ☐ Suspected skin cancer
- ☐ Actinic keratosis
- ☐ Benign skin growth: skin tags; warts, seb K's or other: ______________________________

Skin rash:

- ☐ Psoriasis [Rapid Access Clinic]
- ☐ Eczema/Dermatitis
- ☐ Acne or rosacea
- ☐ Other: ______________________________

☐ Skin cancer screening or "mole check"

☐ Other: ______________________________

Previous history: ☐ Melanoma ☐ Non-melanoma skin cancer

Please include other relevant info: ______________________________

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* Kindly fax **completed form**, all **previous skin pathology reports**, an up to date **list of meds, past medical history & allergies** and relevant **investigations** to 1-866-877-1923