

REFERRAL FORM FAX 905.828.4130

FROM:

Dr. _____

Billing #: _____

Telephone #: _____

Physician:

Dr. Adam Mamelak

Dr. Howard Harris

Dr. Miriam Hanson

First available appointment

Patient Name:

Patient Address:

PATIENT PHONE:

Home: _____

Work: _____

Patient OHIP #: _____

Version: _____

Patient DOB: _____

Reason for Referral (please check):

Skin check

Eczema

Rule out Skin Cancer

Acne/Acne scarring

Rosacea

Cosmetic Dermatology

Mole removal

Psoriasis

Skin Pigment Changes

Other (please specify):

****OHIP does not cover the removal of benign lesions, such as skin tags, moles, keratosis & cysts****

DERMATOLOGY CONSULTANTS
Cosmetic, Medical & Surgical Dermatology

**PLEASE ENCOURAGE YOUR PATIENT TO GO TO
WWW.DERMATOLOGYCONSULTANTS.CA AND FILL IN
THEIR 'NEW PATIENT INTAKE FORM' PRIOR TO THEIR
ARRIVAL**