SKIN CANCER CARE

SKIN CANCER REFERRAL FORM

Skin cancer care referrals will be triaged and assigned to physicians based on availability to ensure patients are seen in the most timely and appropriate manner

Name: ____

DOB: ______________ Today's Date: ______________
MM DD YY

Address: ____

City: ________________ Province : ________________

Postal Code: ____

Home Phone: ____

Cell Phone: ____

Work Phone: ____

OHIP: ______________ Version Code: ______________

Email: ____

Referring Physician Information

Physician Name: _______________________________

Billing Number: ________________________________

Fax: ____

Referring Physician Signature:

____

Family doctor name and fax number:
(if you would like us to copy them on any correspondence)

____

____

Are you part of the following?

☐ FHO ☐ FHT ☐ FHG ☐ FHN ☐ N/A

☐ For suspected skin cancer/biopsy ☐ For surgery from biopsy proven skin cancer Diagnosis: ☐ BCC ☐ SCC ☐ LM ☐ Other

Additional Information: ____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

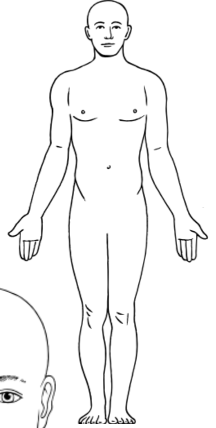
____

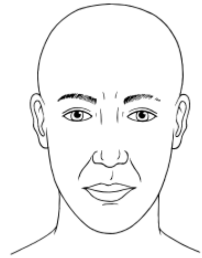
____

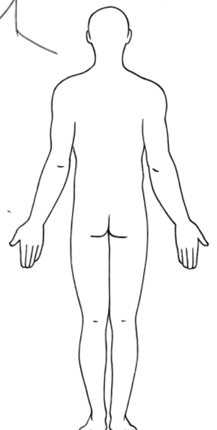
____

____

____







www.skincancercare.ca

Fax: 1.888.372.1123

OWEN SOUND | COLLINGWOOD | OTTAWA WEST | ORILLIA | KINCARDINE |