Skin Cancer Clinic Referral Form

Royal Victoria Regional Health Centre
201 GEORGIAN DRIVE, BARRIE, ONTARIO L4M 6M2
Phone: 705-728-9090 Ext. 43305

Date of Referral (D/M/Y): _____

PATIENT INFORMATION

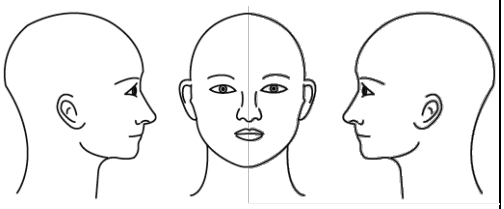
Last Name	**First Name**	**Gender** ☐F ☐M ☐other	**D.O.B** D/M/Y	**Phone**
Address	**City**	**Postal Code**	**OHIP # (with version code)**	
Other Contact Person or POA (Name & Phone)		**Access Information** ☐ Wheelchair required ☐ Hearing impaired ☐ Visually impaired ☐ Translation needed (please state language: _____)		
Allergies	**Patient history of** ☐ **ESBL** ☐ **MRSA** ☐ **VRE**	**Medications (☐ Attached medication list/CPP)** Is this patient on anticoagulants? ☐No ☐Yes, Specify: _____		

SUPPORTING INFORMATION

SECTION A – Biopsy Not Completed

Site	Tumour Size	Suspected Diagnosis
1.		
2.		
3.		

☐ Right ☐ Left



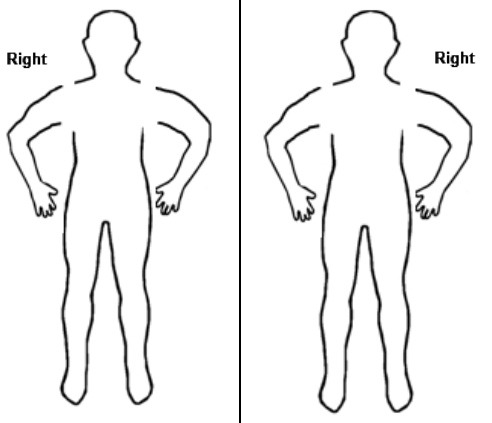
SECTION B – Biopsy Complete, Pathology Positive For Cancer

Site	Tumour Size	Diagnosis
1.		
2.		
3.		

☐ **Pathology report attached.**
☐ **I have informed my patient of their cancer diagnosis.**

Request for Specific Surgeon? Name of Surgeon: _____
If no request: Patients with melanoma will be referred to surgeon from a list of providers closest to patient's residence. Patients with non-melanoma skin cancers will be scheduled at the first available timeslot at SMRCP's Multidisciplinary Skin Clinic at RVH.

☐ Front ☐ Back



Additional History/Previous Treatment ☐ **Attached CPP (Comprehensive Patient Profile)**

REFERRING PROVIDER INFORMATION

Name	**Billing#**	**Fax #**	**Phone**
Are you the patient's Family Physician? ☐ Yes ☐ No **If no, please include Family Physician Info** **Name**		**Referring Provider's Signature**	
Phone	**Ext**		

Fax your completed form to 705-739-5636