DR. E. SAWYERS. MD, CCFP, FCFP.

Family Medicine & Practicing in Dermatology

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GP DERMATOLOGY REFERRAL FORM

Referring Physician:	**Patient e-mail:**
Patient Name:	**HCN/VC:**
Address:	**DOB:**
Phone:	**Referring Physician Billing#:**

UPLOAD PHOTOS TO PHYSICIAN PORTAL @ www.drsawyers.ca TO ENHANCE TRIAGE ACCURACY

REASON FOR REFERRAL

☐ **SKIN LESION** ☐ **ALOPECIA** ☐ **GENITAL WARTS** ☐ **NAIL UNIT LESION**

Size of lesion in mm: _____ Are you concerned this is Melanoma: ☐Yes ☐No

Location: _____ Duration:_____

ENCLOSURES:☐ Photo (Clinical/Dermoscoic) ☐Past Biopsy Report ☐Past Dermatology Consult

Sx: ☐Tender ☐Bleeding ☐Growing ☐Colour Change ☐Pruritic ☐Other: _____

PHx Skin Cancer: ☐None ☐Melanoma ☐BCC ☐SCC ☐Location & Yr: _____

FHx Skin Ca: ☐None ☐Parent ☐Sibling TYPE: ☐ Melanoma ☐ BCC ☐SCC ☐Other:_____

CLINICAL DESCRIPTION: (lesion type (papule, nodular, macule, cystic), colour, scale, etc)

PAST MEDICAL HISTORY:	**MEDICATIONS:**
	ADR:
DATE:	**SIGNATURE:**