



Patients must agree to conduct the first appointment online, either through their phone or computer. Subsequent appointments, if necessary, will be conducted in-office.

Webpage: www.getskinhelp.com

TEL: (833) 272-7546 | FAX: (888) 593-0807 | EMAIL: refer@GetSkinHelp.com

REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME (Last, First)		D.O.B. (DD-MM-YYYY)	SEX
ADDRESS		PATIENT STICKER	
POSTAL CODE	CITY		
HOME PHONE	CELL PHONE		
HEALTH CARD (With VC)		EMAIL (Mandatory)	

REASON FOR REFERRAL (Diagnosis and/or chief complaint)

<input type="checkbox"/> Skin Cancer or suspected skin cancer	<input type="checkbox"/> Dermatitis	NOTES
<input type="checkbox"/> Acne	<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Vitiligo	<input type="checkbox"/> Eczema (Atopic Dermatitis)	
<input type="checkbox"/> Melasma	<input type="checkbox"/> Rosacea	

REFERRING PROVIDER

NAME	PHONE	OFFICE STAMP
ADDRESS	FAX	
OHIP NUMBER	SIGNATURE	