Dermatology Clinic

REFERRAL FORM

Referring physician / nurse practitioner

Name ______________________________

Address ______________________________

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Phone ______________ Fax ______________

Billing No. ______________________________

Date ______________________________

Request ☐ Consult only ☐ Assume care

Urgency ☐ Routine ☐ Soon ☐ Urgent

Patient information

Name ______________________________

Address ______________________________

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Birthdate ______________ Sex __________

Language ______________ Interpreter? Y / N

Personal Health No. ______________________________

Parents' name(s) ______________________________

Primary phone No. ______________________________

Reason for consultation / provisional diagnosis (including assessments/labs and related previous treatments)

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Significant past medical history

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Fax referral to 604-875-3076

Or mail to B.C. Children's Hospital, Dermatology Department, 4480 Oak Street, Vancouver, BC 6H 3V4

PHONE 604-875-2606 l INTERNAL REFERRALS FAX 3076

(Form: May 2019)