301-1637 Woodroffe Avenue
Ottawa, ON, K2G 1W2
Fax: 613-421-4251

GP Dermatology Referral Form

Referring Physician: Billing#:

Patient Name: HCN/VC:

Address:

DOB: Phone: Email:

Please check one:

☐ Dr. Danielle Hamilton (Français/English) ☐ Dr. Fan Mo ☐ First available

Reason for Referral:

☐ Acne ☐ Skin cancer ☐ Vitiligo

☐ Dermatitis ☐ Hyperhidrosis ☐ Rosacea

☐ Psoriasis ☐ Drug rash ☐ Suspected melanoma

☐ Hair Loss ☐ Skin check ☐ Other:______________________

Please provide a brief history so we can triage appropriately:

Past medical history: Medications:

Allergies: Past biopsy (date, site, result):

Date: Signature: