PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Patient Name (Last, First): ______________________

Telephone # (Best Daytime): ______________________

Date of Birth (DD/MM/YYYY): ______________ Sex: F M

Health Card #: ______________ Version Code: ______

# TELEDERM REFERRAL FORM

Fax to **Uxbridge site: 905-862-2005**
Markham site: 905-472-7088

**Referring Physician:**(print) ______________ Signature: ______________ Date: __________
(*must be registered with the Markham Stouffville Hospital Telederm program to refer.)

**Telederm Clinic Site Requested:** ☐ MSH ☐ UXB ☐ LTCH **Urgency of Referral:** ☐ 24hrs ☐ 1 Wk. ☐ 1 Mo.

**Chief Complaint:** ______________________________

**Clinical History Relevant to Chief Complaint:**

______________________________
______________________________
______________________________
______________________________
______________________________

## Symptoms

- ☐ Itching
- ☐ Tenderness
- ☐ Bleeding
- ☐ Burning
- ☐ Pain
- ☐ Sleeplessness
- ☐ Fever
- ☐ Other

## Primary Lesion Description

- ☐ Unknown
- ☐ Scaly Papules
- ☐ Smooth Papules
- ☐ Scaly Plaques
- ☐ Smooth Plaques
- ☐ Erythematious Macules and Patches
- ☐ Non-blanching Purpura/Petechiae
- ☐ Eschar
- ☐ Vesicles, Bullae or Pustules
- ☐ Erosion or Ulcer
- ☐ Pigmented Lesion
- ☐ Hyper or Hypo-Pigmentation
- ☐ Nodules, Cysts or Tumors

## Chronicity

- ☐ Intermittent
- ☐ Constant
- ☐ Other

______________

## Location of Lesion

- ☐ Truncal
- ☐ Hands
- ☐ Feet
- ☐ Palms and Soles
- ☐ Face
- ☐ Scalp
- ☐ Genitals
- ☐ Injection or Trauma Site
- ☐ Other

______________

## Distribution

- ☐ Localized
- ☐ Scattered or Few
- ☐ Other

______________

## Previous Medical Condition

- ☐ Eczema
- ☐ Skin Cancer
- ☐ Autoimmune Disorder
- ☐ Hay Fever/Rhinitis/Asthma
- ☐ Psoriasis
- ☐ Acne/Rosacea
- ☐ Hyperhidrosis
- ☐ Previous Skin Surgery
- ☐ Other ______________

## Specify Lesion to be Photographed

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

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# TELEDERM REFERRAL FORM

Fax to **Uxbridge: 905-862-2005**
Markham: 905-472-7088

**Significant Medical History and Other Relevant Health Problems:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Current Medications:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Current Occupation:** _________________________________ **Country of Origin:** _________________________________

**Allergies (Medication and/or Environmental):**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

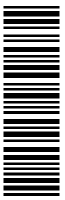
**Previous Treatment/Medication tried for this condition:**

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________



**Response to Treatment:** ☐ Improved ☐ Worsened ☐ No Change

**Relieving Factors:** ______________________________________________________________

**Exacerbating Factors:** ______________________________________________________________

**Recent Travel (Location & Dates):** ______________________________________________________

**Recent Environmental Exposure:** ______________________________________________________

**Relevant Family History:** ______________________________________________________________

**Family Physician Information**

**Name:** ___________________________ **Tel:** ______________________ **Fax:** ____________________

**Address:** __________________________________________________

**Email:** __________________________________________________