



PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

TELEDERM REFERRAL FORM

Fax to **Uxbridge site: 905-862-2005**

Markham site: 905-472-7088

Patient Name (Last, First): _____

Telephone # (Best Daytime): _____

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

Health Card #: _____ Version Code: _____

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
- Erythematous 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



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: 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: _____

