TORONTO DERMATOLOGY CENTRE
Medical, Cosmetic & Laser

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DERMATOLOGY REFERRAL FORM

Consults typically seen within 2 weeks. Please fax this form to (416) 633-0002.
We will contact the patient directly to book appointment.

Patient name: _____

Health Card/VC: _____

Telephone: _____

DOB: _____

(or label)

Reason for referral:

☐ General Dermatology (describe below)

☐ Skin Cancers & Mole Examination Clinic

☐ Warts & Molluscum Clinic

☐ Plastic Surgery Clinic (skin procedures; staffed by plastic surgeons)

Referred by: _____

Phone/Fax: _____

Provider no.: _____

(or stamp with provider no.)

Appointment: _____