hospital ORILLIA
SOLDIERS' MEMORIAL

TELEDERM REFERRAL FORM

Patient Information (affix label here)
First Name: _____
Surname: _____
Phone Number: _____
DOB: _____
Health Card No. _____

Referring Physician: _____

Consulting Physician: _____ Any ___
(check any if no specific consultant is requested)

Urgency of Referral: ____ 24 hrs. ____ 1 wk. ____ 1 mo.

A. Chief Complaint: _____

B. Clinical History Relevant to Chief Complaint: _____
_____
_____
_____

C. Symptoms:
____ Itching _____
____ Tenderness _____
____ Bleeding _____
____ Burning _____
____ Pain _____
____ Sleeplessness _____
____ Other _____

D. Chronicity:
____ Intermittent
____Constant
____ Other _____

E. 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

F. Location of Lesion:
____ Extremities –specify:
_____
____ Truncal
____ Hands R___ L___
____ Feet R___ L___
____ Palms and Soles
____ Face
____ Scalp
____ Genital
____ Injection or Trauma Site
____ Other

G. Distribution:
____ Localized
____ Scattered or few
____ Other _____

Patient Information affix label here)
First Name: _____
Surname: _____
Phone Number: _____
DOB: _____
Health Card No. _____

TELEDERM REFERRAL FORM
(Continued)

H. Previous Medical Condition:
____ Eczema
____ Skin cancer
____ Autoimmune Disorder
____ Hay Fever/Rhinitis/Asthma
____ Psoriasis
____ Acne/Rosacea
____ Hyperhidrosis
____ Previous Skin Surgery
____ Other _____

I. Specify Lesion to be Photographed:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

J. Other Relevant Health Problems: _____
_____
_____
_____
_____

K. Current Medication List: _____
_____
_____
_____
_____

L. Medication and/or Environmental Allergies: _____
_____
_____

M. Previous Treatment/Medication Tried for this Condition: _____
_____
_____

N. Response to Treatment: _____
_____
_____

fax Telederm Referral Form to 705-327-9181
Aug. 30, 2012