Soldiers' MEMORIAL HOSPITAL Orillia

TELEDERM REFERRAL FORM

Fax: (705) 327-9181
Telephone: (705) 325-2201 ext. 6044

Apply Patient Label Here
with min. of
Name, DOB, Health Card #

PATIENT INFORMATION

Name: ___________________________________ DOB: ________________ (YY/MM/DD)

HCN #: __________________________________ Version: ______ Occupation: __________________

Telephone #: ______________________________ Private Insurance Coverage: __________________

REFERRAL INFORMATION

Referring Physician: _______________________________________ CPSO #: ________________________

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

Chief Complaint: ____

Clinical History Relevant to Chief Complaint:____

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Symptoms:
- ☐ Itching
- ☐ Tenderness
- ☐ Bleeding
- ☐ Burning
- ☐ Pain
- ☐ Sleeplessness
- ☐ Other ______________________

Location of Lesion:
- ☐ Extremities: Specify ____________
- ☐ Truncal
- ☐ Hands R_______ L _________
- ☐ Feet R ________ L _________
- ☐ Palms and Soles
- ☐ Face
- ☐ Scalp
- ☐ Genital
- ☐ Injection or Trauma Site
- ☐ Other ______________________

Chronicity:
- ☐ Intermittent
- ☐ Constant
- ☐ 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 ________________________

Primary Lesion Description:
- ☐ Unknown
- ☐ Scaly Papules
- ☐ Smooth Papules
- ☐ Scaly Plaques
- ☐ Smooth Plaques
- ☐ Erythematous Macules & Patches
- ☐ Non-Blanching Purpura/Petechiae
- ☐ Eschar
- ☐ Vesicles, Bullae or Pustules
- ☐ Erosion or Ulcer
- ☐ Pigmented Lesions
- ☐ Hyper or Hypo-Pigmentation
- ☐ Nodules, Cysts or Tumors

Specify Lesion to be Photographed:

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Other Relevant Health Problems:

Current Medication List:

Medication and/or Environmental Allergies:

Previous Treatment / Medication Tried for this Condition:

Response to Treatment: