YORK DERMATOLOGY
CLINIC & RESEARCH CENTRE

Patient Referral

Unit 2-245 West Beaver Creek Road, Richmond Hill, ON, L4B1L1
T:(905)883-7997 F: (905)883-7994 E-mail: info@yorkderm.ca

Date:_____

Patient Demographics

Name: _____
Date of Birth: _____ Sex:____
(mm/dd/yyyy)
HC: _____
Address: _____
_____

Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____

Reason of Referral

Referral for: ☐ Dermatology ☐ Hidradenitis Suppurativa Clinic (Dermatologist + Surgeon) ☐ Rheumatology

☐ Allergist/Immunologist

Presenting problem:

Relevant past medical history & allergies:

Referring Doctor Information

Referring Physician: _____
Billing number: _____
Address: _____
Phone: _____ Fax: _____

For urgent matters requiring consultation in less than 3 days,
please email **info@yorkderm.ca**