Referral and Consultation Request

To:

Bayview North Dermatology Clinic

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Priority: Routine ☐ Urgent ☐

Patient's Full Name: ______________________ Date of Birth: ______________

Home Phone #: ______________________ Health Card #: ______________________

Reason for referral: ____

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Medications: ____

Allergies: ____

Referring Doctor: ______________________ Date: ______________________

Provider #: ______________________

Address and phone: ______________________