NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

MARKHAM MELANOMA AND PIGMENTED SKIN LESION REFERRAL

Please fax referral form and all relevant documents to: 905-472-7603

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

☐ **Emergent (seen within 48 hours)**
Reason: _____

☐ Urgent (seen within 1 week)

Referral Date (mm/dd/yy)	**Referring MD**	**Signature**	**Billing #**

Telephone	**Fax**	**Address**

Spoken Language if other than English	Contact Information for Translator if Required (Name & Number) **Please bring a translator to the appointment if required.**

Diagnosis: _____

_____

_____

Location: _____

☐ Malignant Melanoma ☐ Lentigo Maligna ☐ Dysplastic Nevi (Adult and Paediatric)

Patient aware of diagnosis: ☐ Yes ☐ No

Referral information and supporting documentation

☐ Date of Surgery/Biopsy: _____

☐ Pathology report(s) included*

☐ Imaging and laboratory investigations included

☐ Vertical height on pathology: _____

☐ Ulceration: ☐ Yes ☐ No

*** Patients must have confirmed pathology for referal**

*** * * Please fax all referral forms and all relevant pathology results and supporting documentation * * ***