NOTE: Incomplete and / or unsigned requistions will be returned

Markham Melanoma and Pigmented Skin Lesion Referral

Please fax referral form and all relevant documents to: 905-472-7607

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: ____________________

Patient Name: ____________________ (Last / First)

Date of Birth: ____________________ (Day / Month / Year) Sex: F M

Health Card # ____________ Version Code: ____________

☐ WSIB # ____________ ☐ Non OHIP (Self--pay) or Refugee

Address: ____________________ Postal Code: ________

Telephone # (Best Daytime): ____________________

Alternate #: ____________________

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

☐ Urgent (seen within 1 week)

Referral Date (dd/mm/yyyy)	**Referring MD**		**Signature**	**Telephone**
CPSO #	**Billing #**	**Address**		**Fax**
Preferred Language		Name & number of interpreter to help schedule appointment, if available **Please bring an interpreter 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 * * ***

M-MARMPSLR (9/22) (9/19)