Alberta Health Services

UNIVERSITY OF ALBERTA

DERMATOLOGY CONSULT REFERRAL FORM FROM PRIMARY CARE PHYSICIANS

Fax to: Dermatology Clinic at 780.407.3003

We are **NOT** accepting consults for the following conditions:

- Cosmetic concerns (including removal of skin tags or other small, benign lesions)
- Leg ulcers/pressure sores
- Warts (unless immunosuppressed)
- Ingrown toenails, onychomycosis
- Lice
- Vulvodynia/pelvic pain
- Patch Test referrals (unless made by a Dermatologist)
- Delusions of parasitosis
- Benign nevi in individuals with low risk of malignant melanoma (total nevus count of <50 and no personal or family history of malignant melanoma

URGENCY:

☐ Routine

☐ Urgent (please provide letter with justification)

PATIENT DEMOGRAPHICS:

Name:

Address:

Telephone: (h)

(w)

(cell)

AFFIX PATIENT LABEL

PHN:

REFERRING PHYSICIAN:

Name:

Address:

Phone:

Fax:

REASON FOR REFERRAL:

Consultation request will not be considered unless all required information is submitted and documentation is legible.

☐ **Rash**

Localization: ____________________

Duration: ____________________ ***Please provide details in a referral letter***

Tentative Diagnosis: ____________________

☐ **Referral to a Specialized Clinic:**

☐ Melanoma (please attach pathology)

☐ Cutaneous lymphoma (please attach pathology)

☐ Autoimmune diseases (please provide diagnosis and referral note)

☐ Vulvar genital skin disease (please attach referral note)

☐ Occupational eczema (please attach referral note and relevant documentation (ie. MSDS sheets)

☐ **Growth/Tumor –**

Localization: ____________________

Duration: ____________________

Ulceration:

Biopsy Done:	Yes ☐	No ☐
Concern of basal cell carcinoma:	Yes ☐	No ☐
Concern of squamous cell carcinoma:	Yes ☐	No ☐
Concern of melanoma:	Yes ☐	No ☐
Concern of other:	Yes ☐	No ☐

Please specify: ____________________

☐ **Hair disease**

☐ **Nail disease**

☐ **Severe psoriasis**

☐ **Hidradenitis suppurativa**