DD / MM / YYYY
PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ DOB: _____/

Health card: _____

Full address: _____

Telephone: _____ Alternate #_____

UDC HAIR LOSS CLINIC at the KAYE EDMONTON CLINIC

Referral Date: _____

REFERRING DERMATOLOGIST INFORMATION (N.B. Referrals accepted from Dermatologists only)
Name:
Duplicate report to be sent to:
REFERRAL CRITERIA
□ Please give a working diagnosis: _____ □ For non-scarring hair loss, please have the following results drawn within the last 6 months (please attach or fax with this form): CBC, TSH, ferritin, (B12, folic acid)
OTHER PERTINENT INFORMATION (eg. PMHx, Rx, Symptoms)

Objectives of the UDC Hair Loss Clinic:

- Aid referring dermatologist with specific diagnosis and/or management issue
- Provide residents and medical students with concentrated exposure to a variety of hair loss issues
- Provide patients with a comprehensive evaluation and management suggestions for their hair condition
- **Referrals are accepted from dermatologists who have completed the referral criteria**. Patients are seen for a 30-minute assessment with follow up done by the referring dermatologist.
    - There are some patients who we will see for a period of 6 – 12 months especially if the recommended therapy is relatively unestablished, however, these patients will be discharged back to the referring dermatologist once that period is over.

I understand that I am responsible for the care of my patient and I agree to see my patient in follow-up for further discussion of management.

Signature of Referring Dermatologist: _____