PCSP Clinic
Primary Care Skin Procedures

Prisma Health Care Collaborative
320 Adelaide St. S., London, ON, N5Z3L2
Phone: (519) 878-8621
Fax: (519) 913-4045

Date of Referral: _____

Patient Demographics (please complete or affix patient label):

Name:_____ Phone#:Home _____ Mobile _____

DOB (Y/M/D): _ _ _ _ _ _ _ _ Age:_____ Sex: _____

HC# (with version code): _____ ___ ___

Address:

****Referrals are currently being accepted for****

Malignant/pre-malignant skin lesion	Lipoma / Epidermal Cyst	Acne/Rosacea	Scar revision	Foreign body removal	Vandenbos / Nail removal
Pyogenic granuloma	Skin tag	Nevi (suspicious and cosmetic)	Seborrheic/actinic keratoses	Skin surveillance	Cosmetic skin procedures (including Botox)

NOTE: Referrals for rashes **may** be accepted – please provide as much information as possible to allow appropriate triage.

Reason for Referral: _____

Location(s): _____ Treatment to date: _____

Is this referral for a cosmetic lesion? **YES☐NO☐UNSURE☐**
Is the patient aware that treatment of cosmetic skin lesions is NOT an OHIP-insured service? **YES☐NO☐**

Past Medical and Surgical History (please circle):
- ☐ Anticoagulation ☐Diabetes ☐Hypertension
- ☐ Previous skin cancer (please include type and location): _____
- ☐ Other relevant history: _____

Current Medications (or attach list): _____

Referring Physician: _____OHIP # (required): _____

Specialty: ER☐ Family Medicine☐ Other: ☐_____

Referring Physician Contact Information (Fax #) :_____

Family Doctor (if different from referring): _____

Rostered to FHT/FHO/FHN: YES☐NO☐Unsure☐ Signature: _____

---- Please attach any previous investigations (lab, imaging, pathology, consultation) ----

For URGENT (same day, <1 week) requests, please call the above number or page #15255 for availability.

Please fax semi-urgent (2-4 weeks) and routine (8-12 weeks)

Dr. Brenna Velker, M.D., Ph.D., C.C.F.P. Focused Practice (Dermatology)
Dr. Kate Austin, M.D., C.C.F.P.
Dr. Caitlin Symonette, M.D., M.Sc., F.R.C.S.C. (Plastic Surgery)