Central Island Skin Biopsy Clinic Referral Form

Patient Information: (affix label or complete) **Name:** **PHN:** **DOB:** (mm/dd/yyyy) **Address:** **Home Phone:** **Alternate Phone:** □ Cell □ Work □ Other: (Phone Number) **Email:** **Secondary Contact:**	**Referring Physician:** (stamp or complete) **Name:** **MSP#:** **Address:** **Phone:** **Fax:** **If applicable, Walk-in Clinic name:** **Family Physician:** (if not referring MD)

Date: (mm/dd/yyyy)	**Location:** □ Face □ Torso □ Extremity	□ Pigmented □ Nonpigmented

Duration of Symptoms:
□ < 1 Month □ < 6 Months □ Longstanding

Symptoms: (please select all the apply)
□ Bleeding □ Pain □ Scaly □ Changing

□ Family History Skin Cancer
□ Previous Skin Cancer: (Please List)

Medication List:

Allergies:

Medical History:

Fax completed form with relevant history to 250-244-3551
If you have received this fax in error, please contact the referring physician.
Thank you.

Disclaimer - This clinic provides expedited assessment for patients with a specific lesion. Once the lesion has been addressed, the patient will be discharged from our care. General skin checks or ongoing surveillance for skin cancer are not included and remain the responsibility of the referring physician or primary care provider.