

**Dr. Carley N. Cooper BSc. MD CCFP (EM) Dip (SC)**

Family Medicine with Skin Cancer Focus

201 -1125 Dufferin Crescent, Nanaimo, BC

Phone:(250) 755-1005 Fax: (250) 244-3551

**Patient 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)

**Reason for Referral:** (please select at least one)

- ☐ Skin biopsy of suspicious lesion
- ☐ Actinic keratosis management
- ☐ Pigmented lesion assessment
- ☐ Other:

**Location:**

**Size:**

**PLEASE ATTACH PERTINENT CLINICAL INFORMATION INCLUDING MEDICATIONS AND ALLERGIES WITH YOUR REFERRAL.**

**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.