GREY BRUCE SKIN CANCER PROGRAM

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Referral Form

fax: (226) 270-8509

PATIENT INFORMATION	REFERRING MD INFORMATION
Name: **Gender:** **Email:** **Cell #:** **Home #:** **Address:** **HNC** *(with version code)*:	**Name:** **Billing number:** **Phone:** **Email:** **Fax:**

PLEASE USE ONE FORM PER LESION

LOCATION

- ☐ Head & Neck *(above clavicle)*
  - ☐ Specify: ____________
- ☐ Body *(below clavicle)*
  - ☐ Specify: ____________

SIZE: __________ cm

DURATION: _________ wks / mts / yrs

☐ **SUSPECTED SKIN CANCER (not biopsied)**

- ☐ **URGENT:** ***(suspicious for melanoma or rapidly growing tumor)***

☐ **BIOPSY PROVEN** (*please attach biopsy report*)

- ☐Punch | ☐ Curette | ☐ Excisional
- **Dx:** ☐ BCC | ☐ SCC | ☐ Melanoma
- ☐ Other: ______________

☐ Extensive actinic keratosis for consideration of field therapy