

Minor Procedure Referral Form

 380 King St N, Unit 5, Waterloo, ON N2J 2Z3
 Phone: 519-579-8858 | Fax: 226-777-8211

Patient Information			
First Name:		Last Name:	
Sex:		Phone:	
Address:			
Health card # :		D.O.B (yyyy/mm/dd):	

Referring Physician Information			
Date of Referral:			
Name:			
Clinic Phone:		Clinic Fax:	
OHIP Billing Number:		CPSO:	

Note to Referring Physicians	
<p>The consults would be billed as A905 and should not result in any financial penalties.</p> <p>Now accepting referrals for diagnostic clarification of suspicious lesions i.e skin cancer, moles</p> <p>Exclusions: Things that should NOT be referred:</p> <ul style="list-style-type: none"> • Large lesions that would require skin grafts or extensive suturing • Cysts >2 cm 	<div style="border: 1px solid black; padding: 10px; width: 100%;"> Clinic stamp here </div>

List of Services

Joint and Soft Tissue Injection
Knee Joint <input type="checkbox"/> Shoulder Joint <input type="checkbox"/> Other (please specify): _____

Lumps and Bumps
Inclusion/Sebaceous Cyst Removal <input type="checkbox"/> Pilar Cysts <input type="checkbox"/> Mole/skin tag removal <input type="checkbox"/> Cryotherapy of warts/keratosis <input type="checkbox"/> Benign skin lesion removal <input type="checkbox"/> Skin biopsies <input type="checkbox"/> Other (please specify): _____

Other Procedures
Abscess drainage <input type="checkbox"/> Stitching & suture/staple removal <input type="checkbox"/>

Important Medical History (Please Check All That Apply)
On anticoagulants <input type="checkbox"/> Chronic steroid therapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Active malignancy <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/>

Medication List (Please Ask Patients To Bring All Medications to the Appointment)

Clinical Information