Patient Referral Form

Give this form to your patient, instruct them to email it to info@dermcafecanada.com

***Required**, **incomplete Referrals are not accepted**

Referring Physician Information

Referring Doctor/Nurse Practitioner's Title and Name*

Referring Doctor's Billing Number*

You must provide a contact email OR fax number below*

Referring Doctor's Secure Email. Please ensure accuracy.

OR

Referring Doctor's Fax. Please ensure accuracy.

Is this patient part of a FHO/capitation practice?*

- ( ) **Yes**
- ( ) **No**
- (•) **Not sure**

All consults seen by FRCPC Dermatologists. Accutane follow ups seen by GP-Derms with designation to maintain low wait-times (AKA ABSOLUTELY NO NEGATION)

Referring Doctor's Phone

Reason for Referral*

Please review our virtual-only scope of practice at: dermcafecanada.com/referral

Patient Information

Patient's First Name*

Patient's Last Name*

Patient/Guardian's Email*

We are a VIRTUAL-ONLY clinic, **this is not optional.**
Please ensure accuracy.

Confirm Patient/Guardian's Email*

Emails must match.

Patient/Guardian's Phone Number*

☐ **By checking this box, the above named patient and provider(s) consent to be contacted by DermCafé via email, fax, text messaging or phone call. This is required for use of DermCafé services.** * View the patient and provider consents on dermcafecanada.com/referral

DermCafé is a VIRTUAL-ONLY dermatology clinic. If patient is uncomfortable with standard technology (email, webpages), DermCafé is NOT the right service for them.

NEXT STEP: email this form to info@dermcafecanada.com