Stratica Dermatology
200, 10140 – 117 Street
Edmonton, AB T5K 1X3
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www.StraticaMedical.ca

Dermatology Referral Form

Date:

Patient Label

Patient Demographics

Leave below section blank if patient label with completed demographics is included above.

Patient Last Name:	Given Name(s):
Address:	Gender: oMale oFemale oOther
City:	Postal Code:
Home #:	Cell #:
PHN:	DOB:

Referring Physician Information

Referring Physician: PRACID:

Practice Phone Number: Fax Number:

O I am an all-call resident from University of Alberta (select if applicable)

Practitioner Request:

o First Available

Dermatologists

o Dr. A. Ferrier o Dr. M. Samycia o Dr. T. Vu. o Dr. M. Ladha o Dr. L Soong

General Practitioners with Dermatology Diploma

o Dr. A. Mirza o Dr. L. Wicentovich

Reason for Referral

O Acne	O Chronic Sweating	O Mole Check	O Rosacea
O Atopic Dermatitis	O Hair Loss	O Positive Biopsy	O Vitiligo
O Chronic Migraine	O Lesion	O Psoriasis	O Wart
OOther:			