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cmsderm.ca

Patient Referral

Date: _____

URGENCY: **URGENT** (*Query melanoma, suspected skin cancer, severe flare eczema, psoriasis — seen within 2 weeks*) **ROUTINE**

Patient Demographics

Name: _____	Phone: _____
Date of Birth: _____ Sex: _____ <small>(mm/dd/yyyy)</small>	Cell Phone: _____
Health Card #: _____	Work Phone: _____
Address: _____	Email: _____

Reason for Referral

Referral for:

Query melanoma Skin lesion / mole assessment Procedural dermatology
 Psoriasis Eczema / Atopic Dermatitis Phototherapy
 Rash — undiagnosed Alopecia Areata/Scarring Alopecia Patch testing Other: _____

SPECIALIZED SERVICES (limited availability in Durham Region):

Phototherapy (*psoriasis, vitiligo, eczema, pruritus, mycosis fungoides*) Patch Testing (*contact/occupational dermatitis*)

Presenting problem:

Relevant past medical history, medications & allergies:

Referring Physician Information

Referring Physician: _____

Billing #: _____

Address: _____

Phone: _____

Fax: _____

URGENT referrals (query melanoma, suspected skin cancer, severe flares) **seen within 2 weeks**
Please mark referral URGENT and include brief clinical concern for triaging

Fax referrals to: (905) 493-1170 | Questions: (905) 493-5700

This practice focuses on adult dermatology.