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DERMATOLOGY REFERRAL FORM – PLEASE FAX TO 780-428-5556

Date: ________________

Patient label
or contact info:

Consultant requested: first available   Dr. P. Grewal   Dr. N. Wasel

Reason for referral:

Relevant medical
history & medications:

Referred by:
(name, contact info
or stamp)
& PRACID number:

Signature: ________________________________