Appendix 3: Dermatology Telemedicine Consultation Request Form

Capital Health

Date of Request: _____

Urgent? _____

Specialist to be consulted: _____

Patient attending clinic at: _____ **Hospital**

Hospital Telephone: _____ **Hospital Fax:** _____

The following must be completed otherwise form will be returned:

Patient Name: _____

Address: _____ Civic Address: _____

_____ _____

City/County: _____ Postal Code: _____

Date of Birth (YY/MM/DD): _____

Health Card # _____ Exp. Date: _____

Phone (work): _____ Phone (home): _____

Next of Kin: _____ Marital Status: _____ Maiden Name: _____

Referring Physician: _____ Phone: _____

Purpose of Referral: _____

_____

_____

_____

_____

Medications: _____

1: Topical _____ _____

2: Oral _____ _____

Allergies: _____ Type of Reaction: _____

Drug: _____ Type of Reaction: _____

Other: _____

Physical Examination: Note: Rashes must be clearly visible to be seen via telemedicine

_____

_____

_____

_____

Telemedicine Consult Date: _____ Time: _____