Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

18127

NOTE: PLEASE FILL OUT COMPLETELY or PLACE A PATIENT LABEL HERE

Patient Name : _____

Visit Number : _____

CR Number : _____

PATCH TESTING REFERRAL FORM

Date of Referral : _____ (yyyy/mm/dd)

PATIENT INFORMATION:		
Patient Name:	Date of Birth: _____ (yyyy/mm/dd)	Health card number: Version Code:
Patient Address:		Telephone number: Home: _____ Work: _____ Cell: _____

Patient complaint / diagnosis suspicion:

Relevant history (must be filled out):

Previous patch testing and reports (if available):

Date of previous patch testing: _____(yyyy/mm/dd)

REFERRING CARE PROVIDER INFORMATION:

_____

Designation Printed Name Signature (must be signed)

_____

Address Billing Number (mandatory)

_____

Telephone Number Fax Number

PATCH TESTING REFERRAL TELEPHONE NUMBER: 613-544-3400 Ext. 23415
PLEASE FAX ALL CORRESPONDENCE TO : 613-545-2202