iHealthMD medical centre

iHealthMD Skin Centre and Acne Clinic
Referral Form Fax: 604-971-6768

Please note, all doctors are Family Medicine Specialists practicing in skin conditions.

Patient Info: Date of referral:_____

Name (Last, First): _____ DOB (YYYY/MM/DD): _____

PHN: _____ ☐ M ☐ F Other (pronouns):_____ Phone #: _____

Email: _____ Address: _____

Referring Practitioner Info: *Practitioner/ Office stamp here:*

Name: _____ MSP number: _____

Fax: _____ MRP (if different): _____

Please submit MSP code 03333 to the doctor of your choosing

Physicians

☐ Dr. Inna Fadyeyeva (66207)

☐ Dr. Romina Moradi (34828)

☐ Dr. Yasamin Rekabdar (J3003)

Is this an urgent referral? Yes ☐ No ☐

Reason for Referral:

Please provide answers for all questions below regarding your patient.

Is your patient immunocompromised?
Yes ☐ No ☐

Does your patient have a history of smoking?
Yes ☐ No ☐
If yes, how many packs/years? _____

Do they have a history of precancerous/ cancerous skin lesions?
☐ ☐

Yes No

Do they have a family history of Skin Cancer?
Yes ☐ No ☐

Does your patient burn easily?
Yes ☐ No ☐

Please note, all hair loss referrals must be sent with a recent set of blood work including TSH and Ferritin.

Please complete this form in its entirety and attach all relevant investigations/ medication lists etc.
Incomplete Referrals will be returned.

Our office will contact patients directly to schedule appointments.

Address: 403–1200 Lonsdale Avenue, North Vancouver, BC, V7M 3H6
Fax:604-971-6768 Tel: 604-971-6767 Email:info@ihealthmd.ca Website: www.ihealthmd.ca

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