North Bay Regional Health Centre

Telemedicine
Dermatology Consult – Store Forward

Fill out form electronically and fax or Fax completed form to: 705-495-7936

Patient Name:		D.O.B.	
Patient Contact Information	Address: City: Postal Code:	HC# Home phone #: mobile #:	
Chief Complaint:			
Referring MD : (please print)		MD Phone #: Fax #: Billing #:	
Urgency:	☐ within 24 hours ☐ within 1 week ☐ within 1 month		
Consulting MD:		Date consult Submitted: ☐ / / (d/m/y) ☐ / / (d/m/y) ☐ / / (d/m/y)	

Grey area to be completed by Telemedicine Coordinator

Clinical History Relevant to the Chief Complaint:

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Enter questions, comments, thoughts, or other relevant information below.
Please be as detailed as possible; the consultant cannot easily contact you or the patient for additional information.

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Symptoms (select all that apply):			**Chronicity**
☐ Itching	☐ Sleeplessness	☐ Burning	☐ Intermittent
☐ Pain	☐ Tenderness	☐ Bleeding	☐ Persistent
Other (specify):			Other (specify):

Relieving Factors:	**Exacerbating Factors:**
______________________________ ______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________ ______________________________
Recent environmental exposure:	**Recent Travel (locations & dates):**
______________________________ ______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________ ______________________________
Treatment/Medication Tried for this condition: ____ ____ ____ ____	Response: ☐ Improved ☐ No Change ☐ Worsened

Colour of the skin:

☐ African American ☐ Caucasian ☐ East Asian ☐ Native American

☐ Hispanic or Latino ☐ Middle Eastern ☐ South Asian

Country of Origin:______________________ **Occupation:**____________________________

Prior Medical Condition

☐ Eczema	☐ Skin Cancer	☐ Prior skin surgery
☐ Hay Fever/Rhinitis	☐ Psoriasis	☐ Acne/Rosacea
☐ Hyperhidrosis	☐ Autoimmune disease	Other (specify): ______________

Other Relevant Health problems:	Risk Factors:
______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________
Current medications:	Drug and/or environmental allergies:
______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________

Significant Medical History:	Relevant Family History:
______________________________________ ______________________________________ ______________________________________	______________________________________ ______________________________________ ______________________________________

Primary Lesion:	**Distribution** (Select all that apply):
Lesion Size: ___________	☐ Localized
☐ Unknown	☐ Extremities
☐ Vesicles, bullae or ulcers	☐ Truncal
☐ Scaly Plaques	☐ Feet
☐ hyper- or hypo pigmentation	☐ Scalp
☐ Nodules, cysts or tumors	☐ Palms and soles
☐ Eschar	☐ Lymphangitic
☐ Smooth papules	☐ Sun-exposed areas
☐ Pigmented lesion	☐ Dermatomal
☐ Erythematous macules and patches	☐ Scattered or few
☐ Non-blanching purpura/petechiae	☐ injection or trauma site
☐ Scaly papules	☐ Flexor
☐ Erosion or ulcers	☐ Extensor
☐ Smooth plaques	☐ Genital
	Body Locations: