SOUTH ISLAND HEMORRHOID CLINIC

Minor Surgical Procedures

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REFERRING PROVIDER

Provider Name: _____ Clinic: _____

Phone: _____ Fax: _____ Billing #: _____

PATIENT DEMOGRAPHICS

Patient Name_____

DOB: _____ PHN:_____

Address:_____

Phone: _____ Cell:_____

Email:_____

PROCEDURE REQUESTED

☐ Lipoma ☐ Sebaceous cyst ☐ Skin lesion / excision ☐ Other: _____

LOCATION / SIZE (if known)

Location: _____ Size: _____

RELEVANT MEDICAL HISTORY

☐ **Anticoagulants** ☐ Bleeding disorder ☐ Diabetes

☐ Other:_____

☐ Patient aware of and consents to referral

Provider Signature: _____ Date: _____