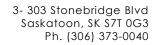




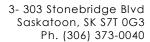
Patient Intake Assessment Form

Name:	_ Date of birth:	Age:
(as it appears on your health card)		-
Address:	Health Card Number	er:
City/Town/Village:		
Cell Phone #:	Home phone #:	
Email Address:		
Family Doctor:		
Pharmacy to send Prescriptions		
Reason for referral to dermatology: *PLEASE NOTE: We request the appointment	t focuses ONLY on the re	ferred condition. If there
are other issues, we may be able to address		-
nature, they can be booke	ed in for a cosmetic cons	<u>sultation.</u>
How long have you had this problem?		
Have you seen a Dermatologist for this condition	n, and when? 🗆 Yes 🕒 No	o If so when?
Which medications or treatments have you tried	for this problem?	
Please list all prescription/non-prescription media		
1.	5.	
2.	6.	
J.	/ •	
4.	0.	
Do you have any medication allergies? \(\sigma\) Yes	■ No If yes, specify?	
Allergy to anesthetic/freezing? Yes No		
Do you have a private insurance plan for your m		vider)
Current/ Previous Occupation:	NIHB • Yes • No	
Correctly Frevious Occupation.		
Skin History:		
Have you had any of the following skin condition	ns2	
□ Actinic Keratoses□ Basal Cell Skin Cancer□ Melanoma□ Blistering Sunburn	□ Squamous Cell Skin Can s □ Atypical Moles	cer
Specify location and date:		
Family medical history of melanoma ☐ Yes ☐ N	No	
Do you wear sunscreen? Yes (what SPF?		
Have you ever used a tanning salon? Never [· · · · · ·	times?
☐ Current tanner: (How often do you go)





Medical History:					
Do you drink alcohol? □ None □ <1 drink per week □ 1-7 drinks per week □ 7+ drinks/wk. Do you smoke? □ Never smoked □ Former smoker □ Current smoker: (# packs smoked per day)					
Please indicate any of your current or previous medical conditions: D. Heart Disease, please specify					
 □ Heart Disease, please specify □ Pacemaker □ Liver Disease: □ Lung Disease: please specify 					
☐ Transplantation: please specify					
□ Neurologic Disease please specify □ Cancer (Type, Year):					
□ Anxiety □ Depression □ HIV/AIDS □ Hepatitis B/C □ Other conditions not listed:					
Are you: Pregnant (How many weeks) Trying to become pregnant Breast-feeding					
CLINIC POLICIES					
We strive to provide the highest quality dermatologic care during your visit. While your Saskatchewan Medicare pays for a wide range of required services provided by physicians, some physician services are not insured by Saskatchewan's Ministry of Health. You are responsible for payment of these uninsured services .					
I acknowledge the following: 1. I understand my referral is valid and I may remain a patient of this clinic for 6 months after my last appointment date. After this I will require another referral unless ongoing Dermatological care is deemed absolutely necessary by a Doctor at this clinic, otherwise my care will be transferred back to my referring doctors care.					
2. I agree to pay the missed appointment fee of \$50.00* for a new appointment and \$30.00* for a followup appointment and \$20.00* for a phototherapy appointment if I do not notify the office at least 24 hours before cancelling/rescheduling/failing to attend my scheduled appointment. Please note patients who fail to attend may be discharged from our practice, back into the care of their referring doctor. *Fees for missed procedures may be higher.					
3. I agree that the costs associated with uninsured medical services including the completion of insurance forms (\$50.00), sick notes (\$25.00), letters of attendance (\$10.00), as outlined by and in accordance with the Saskatchewan Medical Association. For a full list of uninsured services, see the front desk.					
If you have any issues with uninsured services not covered under your Sask health card or with access to Dermatology Specialists, please reach out to your local government representative.					
Signature: Date:					





MEDICAL, SURGICAL, AESTHETIC SPECIALISTS

ZERO TOLERANCE POLICY

The Saskatoon Dermatology Centre is committed to providing a **safe**, **welcoming** and **respectful environment** for our physicians, staff and patients.

Words or actions that make others feel threatened or demeaned will not be tolerated and immediate action will be taken.

Disruptive Behaviour:

The Saskatoon Dermatology Centre considers the use of inappropriate words, actions or inactions as disruptive behaviour.

Inappropriate Actions/Inactions:

- Violence (physical attacks or threats of harm)
- Intimidation
- Throwing, damaging property or breaking things
- Unwelcomed physical contact
- Failure to observe Saskatoon Dermatology Centre policies
- Refusing to leave the property when asked
- Posting negative online comments or bullying our staff or clinic online without allowing us the chance to address any issues

Inappropriate Words (in person, by phone, or any means of communication):

- Abusive language and yelling
- Disrespectful or demeaning language/comments
- Remarks, jokes or innuendos that degrade, ridicule or offend
- Discriminatory remarks
- Threats or threatening behaviour
- Bullying either online or in person
- Sexual Harassment

Immediate action will be taken, and individual(s) may be asked to leave, the police may be called, and the individual(s) may face permanent dismissal from our practice.

If you have any particular concerns or frustrations about our clinic, a staff member or your visit with us, we would appreciate this being brought up with our office manager in person or by emailing manager@saskatoondermatology.ca and we will do our utmost to sort out any issues in a professional and courteous fashion with you.

THANK YOU FOR YOUR KINDNESS.

I have read and understand the ∠ero Tolerance Policy at Saskatoon Dermatology Centre	Ш	have reac	l anc	l undersi	tand the	∠ero	I olerance	Policy	/ at Sa	ıskatoor	n Dermato	ology	Centr	re:
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Signature:	Date:	
Name:		