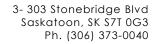




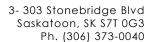
Patient Intake Assessment Form

Name:	_ Date of birth:	Age:	
(as it appears on your health card)		_	
Address:	Health Card Number:		
	Province: Postal Code:		
Cell Phone #:			
Email Address:			
Family Doctor:			
Pharmacy to send Prescriptions			
Reason for referral to dermatology:		ferred condition. If there	
are other issues, we may be able to address			
<u>nature, they can be booke</u>	ed in for a cosmetic cons	<u>ultation.</u>	
How long have you had this problem?			
Have you seen a Dermatologist for this condition	n, and when? 🗆 Yes 🕒 No	If so when?	
Which medications or treatments have you tried	d for this problem?		
Please list all prescription/non-prescription media		ıking:	
1.	5.		
2.	0.		
3. 4.	8.		
	0.		
Do you have any medication allergies? • Yes	■ No If yes, specify?		
Allergy to anesthetic/freezing? Yes No		المراج الجائب	
Do you have a private insurance plan for your n	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	vider)	
Current/ Previous Occupation:			
Concern, Frevious decopation.			
Skin History:			
Have you had any of the following skin conditio	ns?		
☐ Actinic Keratoses ☐ Basal Cell Skin Cancer		cer	
☐ Melanoma ☐ Blistering Sunburns Specify location and date:	■ Atypical Moles		
Family medical history of melanoma Yes	No		
Do you wear sunscreen? Yes (what SPF?			
Have you ever used a tanning salon? ☐ Never		imes?	
☐ 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: Heart Disease, please specify Pacemaker Liver Disease: Kidney Disease:							
□ Pacemaker □ Liver Disease: □ Kidney Disease: □ Lung Disease: please specify							
☐ Transplantation: please specify							
□ Autoimmune Disease: please specify □ Neurologic Disease please specify							
□ Cancer (Type, Year): 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: 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 \$75.00* 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 \$100.00.							
 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:							





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

<u>Inappropriate Words (in person, by phone, or any means of communication):</u>

- 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.

Signature:	Date:		
I have read and understand the Zero Tole	erance Policy at Saskato	on Dermatology	Centre:

Name:			