SASKATOON
DERMATOLOGY
CENTRE
MEDICAL, SURGICAL, AESTHETIC SPECIALISTS

3- 303 Stonebridge Blvd
Saskatoon, SK S7T 0G3
Ph. (306) 373-0040

Patient Intake Assessment Form

Name: _____ Date of birth: _____ Age: _____
(as it appears on your health card)
Address: _____ Health Card Number: _____
City/Town/Village: _____ Province: _____ Postal Code: _____
Cell Phone #: _____ Home phone #: _____
Email Address: _____
Family Doctor: _____
Pharmacy to send Prescriptions _____

Reason for referral to dermatology: _____

PLEASE NOTE: We request the appointment focuses ONLY on the referred condition. If there are other issues, we may be able to address these at additional visits or if they are cosmetic in nature, they can be booked in for a cosmetic consultation.

How long have you had this problem? _____

Have you seen a Dermatologist for this condition, and when? ❑ Yes ❑ No If so when?
_____

Which medications or treatments have you tried for this problem?
_____
_____

Please list all prescription/non-prescription medications you are currently taking:

1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have any **medication allergies**? ❑ Yes ❑ No If yes, specify? _____
Allergy to anesthetic/freezing? ❑ Yes ❑ No
Do you have a private insurance plan for your medications? (if yes, list provider)
_____ NIHB ❑ Yes ❑ No
Current/ Previous Occupation: _____

Skin History:

Have you had any of the following skin conditions?
❑ Actinic Keratoses ❑ Basal Cell Skin Cancer ❑ Squamous Cell Skin Cancer
❑ Melanoma ❑ Blistering Sunburns ❑ Atypical Moles
Specify location and date: _____

Family medical history of melanoma ❑ Yes ❑ No
Do you wear sunscreen? ❑ Yes (what SPF? _____) ❑ No ❑ Sometimes
Have you ever used a tanning salon? ❑ Never ❑ In the past: (How many times? _____
❑ Current tanner: (How often do you go tanning per year? _____)

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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: _____
❑ Lung Disease: please specify _____
❑ Transplantation: please specify _____
❑ Autoimmune Disease: 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 **$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**.

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:** _____

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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 Zero Tolerance Policy at Saskatoon Dermatology Centre:

Signature: _____ **Date:** _____

Name: _____