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PATIENT REFERRAL

Patient's Medical History (Referring doctor to complete)

Is the patient allergic to any drugs or local anaesthetic? YES NO

Details:

Are they currently taking any medications?

Do they a history of any of the following:

Heart disease

Kidney disease

Liver disease

Eye disease

Details:

Please tick which skin condition you would like to refer your patient for:

- | | |
|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> NMSC Assessment and Treatment |
| <input type="checkbox"/> Alopecia | <input type="checkbox"/> Occupational Contact Dermatitis |
| <input type="checkbox"/> Atopic Dermatitis | <input type="checkbox"/> Oral Mucosal Conditions |
| <input type="checkbox"/> Epidermolysis Bullosa | <input type="checkbox"/> Patch Testing |
| <input type="checkbox"/> Hidradenitis suppurativa | <input type="checkbox"/> Podiatry Dermatology |
| <input type="checkbox"/> Hyperhidrosis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Male/female hair loss | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Medical Photography Services | <input type="checkbox"/> Trichotillomania |
| <input type="checkbox"/> Melanoma Assessment and Treatment | <input type="checkbox"/> Verruca vulgaris |
| <input type="checkbox"/> Men's Health | <input type="checkbox"/> Vitiligo |
| <input type="checkbox"/> Nail conditions | <input type="checkbox"/> Other |

Please detail: