Dermatology Referral Form

Patient Details		**Referring GP details**	
First name		GP name	
Surname		Practice	
Address		Address	
Date of birth		Telephone	
Sex		Fax	
NHS number		Date referral sent	
Home telephone			
Mobile telephone			
Occupation			

Reason for referral	**Type of skin problem**
Diagnosis ☐ **Treatment failure** ☐ **Treatment only available in secondary care** ☐ **Other, please specify** ☐	**Lesion** ☐ **Non-Lesion** ☐
Onset	**Duration**
Site	
Description • number and size, • symmetry, distribution • colour, border • shape, surface features/texture, • type of lesion (raised,flat,bullous,pustules,ulceration, erosions,fissure,wheal,cyst, comedone, scar)	
Symptoms e.g. pruritus, pain, bleeding	
Precipitating and/or alleviating factors	
Any changes over time?	
Associated body sites e.g. scalp, nails, mucosa, flexures	
Fitzpatrick skin type **I** (pale white skin) **to** **VI** (Dark brown or black skin)	
Investigations and results to date	
Topical/systemic treatments tried to date (including frequency, duration and effectiveness)	
Previous skin conditions	
Relevant family history skin conditions	
Medical History	
Current Medication	

Relevant co-morbidities			
Mobility/frailty	☐	Cognitive impairment	☐
Smoking	☐	Anticoagulants	☐
Immunocompromised	☐		
Photograph attached		Yes ☐	No ☐