vitiligo clinic referral form

FAX TO: 9639 3575

skin&cancer foundation inc
healthy skin by dermatologists

Patient Details

Name: _____

DOB: _____

Address: _____

Phone: _____

GP Details

Name: _____

Address: _____

Phone: _____

Vitiligo Type: ☐ Common (autoimmune ☐ Segmental

For consideration of **Non-Cultured Epidermal Grafting**:

☐ Scar ☐ Piebaldism ☐ Hypochromic naevi ☐ Other: _____

Thyroid auto-antibody test performed ☐ Yes (please attach) ☐ No

Previous UVB therapy ☐ Yes ☐ No

If yes, please provide approx. dates: _____

Additional details: _____

_____

Please indicate an interest in the following services:

☐ Excimer Laser ☐ Camouflage Consultant*

☐ Psychologist† ☐ Semi-permanent micropigmentation

* additional fees may apply for professional advice on camouflage techniques
† counselling sessions are held at different times to the Vitilgo Clinic

Referring Doctor: _____ Provider no: _____

Suburb: _____ Signature: _____

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