COMMUNITY
OUTPATIENTS

Dermatology Referral Form

NHS

Date of Referral:

PATIENT INFORMATION

Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Other ❑ (please specify):

First name: Middle name:

Surname name:

Sex: M ❑ F ❑ Birth date: / /

NHS Number:

House No./Name: Telephone :

Address:

Town: City: County: Postcode:

PREFERRED CLINIC LOCATIONS (Please tick one or more):

St Stephens Medical Centre, Ashford	❑	Oaklands Medical Centre, Stade Street, Hythe	❑
Dover Medical Practice, Maison Dieu Rd, Dover	❑	Minster Medical Centre, Sheppey Community Hospital	❑
Broadway Medical Practice, Broadstairs	❑	Victoria Hospital, London Road, Deal	❑

REFERRING GP INFORMATION

Name of Referring GP:

GP Practice Name:

Address: Telephone:

Town: City: County: Postcode:

Email address for results of consultation:

NATURE OF THE REFERRAL:

Skin Lesion Referral ❑

Skin Rash Referral ❑

URGENCY OF REFERRAL:

Urgent ❑

Within 4 weeks ❑ Within 6 weeks ❑

Description of condition/duration/location – please give as much information as possible:

Treatments tried to date and their effectiveness:

Past medical history/relevant family history:

Current medication:

Reason for referral – please indicate Diagnosis/ Management Problem/ Further Information:

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