URGENT DERMATOLOGY REFERRAL FORM

230 York St, South Melbourne VIC 3205
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www.hopedermatology.com.au

Patient Details

Name: .....

Date of Birth: .....

Best Contact number(s): .....

Reason for referral:

- ❑ Suspected melanoma or rapidly growing tumour(please indicate site) _____
- ❑ Urgent lesion for diagnosis
- ❑ Severe or widespread acute rash
- ❑ Pregnancy associated rash
- ❑ Rapid onset hair loss (eg. alopecia areata)
- ❑ Severe scarring acne
- ❑ Allergic reaction to Medication / Treatment
- ❑ Other: .....

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Referring Doctor Details

Name .....

Practice Address or stamp: .....

.....

Provider Number: .....

Signature: .....

Date: .....

We will endeavour to see urgent referrals within 48 hours.

Fax form to (03) 9686 9898