**URGENT REFERRAL FORM**

**Patient Details (write/label):**

Name:

Date of Birth:

Best Contact numbers:

Reason for Referral:

☐ Suspected melanoma

☐ Rapidly progressive vitiligo

☐ Severe acute rash

☐ Pregnancy associated rash

☐ Severe scarring acne

☐ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Doctor Details:**

Name:

Practice Address or stamp:

Provider Number:

Signature:

Date:

We will endeavour to see urgent referrals within one week of receiving them.

**Please fax form to +61 3 8560 6947**