



THE MELANOMA CENTRE

Patient Referral

Patient Name: _____

Date of Birth: _____

Phone: _____

Reason for referral: _____

PDT ☐ Red-light PDT

☐ Daylight PDT

☐ Please assess and advise

Laser ☐ General pre-laser consultation

☐ Further laser treatment(s)

Full Skin Check ☐

Spot Check ☐

Biopsy ☐

Specify location(s):

Excision *Specify location:* _____

Other: _____

Relevant diagnosis: _____

Relevant clinical information

☐ Previous treatments / response

☐ Relevant history / immunosuppression

☐ Current medicines and allergies

☐ Photosensitivity history / concerns

Please send all referrals via Medical objects, email, or fax

Referring Practitioner: _____

Practice Name: _____

Date: _____



**THE
MELANOMA
CENTRE**

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