Patient Referral Form

Aurora Dermatology
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Aurora Dermatology

P 02 9423 0033 **F** 02 9185 0942 **E** info@auroradermatology.com.au **w** www.auroradermatology.com.au

Referring Provider Name:. . . . . .

Referring Doctor's Provider No: . . . . . .

Referring Provider Phone No: . . . . . Fax No: . . . . . .

Referring Provider Address: . . . . . .

Patient Information

Sex: . . . . . .

DOB: . . . . . Patient Age: . . . . . Preferred Pronouns: . . . . . .

Phone No: . . . . . Mobile Phone No: . . . . . .

Address: . . . . . .

Email: . . . . . .

Reason for Referral

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- ☐ Acne/Acne Scarring
- ☐ Allergy Testing
- ☐ Cosmetic/Anti-Wrinkle
- ☐ Eczema/Dermatitis/Psoriasis
- ☐ Hidranitis Supparativa
- ☐ Excessive Sweating
- ☐ Paediatric Rashes
- ☐ Elderly Skin Rashes
- ☐ Rosacea
- ☐ Shingles
- ☐ BCC, SCC, Melanoma
- ☐ PRP for Hair Loss
- ☐ Hair Transplants
- ☐ C02 Laser
- ☐ Phototherapy

Medications: . . . . . .

Allergies: . . . . . .

☐ Urgent ☐ Next available

Fax the completed referral form to 02 9185 0942 or ask patients to bring referral to their appointment.

Please call our practice for urgent appointments. We aim to see all urgent patients within 48-72 hours.