PATIENT INFORMATION

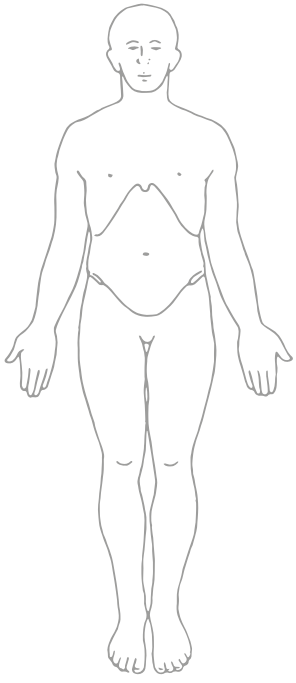
cancer centre london

REFERRAL FORM FOR PHOTODYNAMIC THERAPY

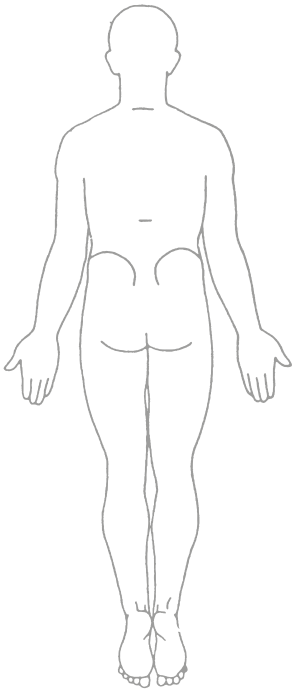
Surname:	Referring Consultant:
First Name:	Diagnosis:
Tel No:	
Mobile No:	
Histology Report Provided:	
Allergy:	
Previous Treatment: (Specify)	
Number of Treatments Required:	
Comments:	

Mark on Diagram Area to be Treated: **PLEASE BE AS SPECIFIC AS POSSIBLE**

FRONT



BACK



Dermatologist signature: