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ID..... **Occupation.....**

SECTION A

Clinical History

Reason for consultation: diagnosis, confirmation of diagnosis, recommendations for management, medical evaluation, treatment recommendations, other.....

Duration: months, years, unknown, other.....

Distribution of rash (i.e. where is it on the body).....

Skin symptoms: pruritus, pain, bone, other.....

Other skin symptoms.....

Systemic Symptoms.....

Medications prior to onset of this skin rash? Specify.....

Possible contact exposure? Specify.....

Others affected by this rash? Specify.....

Past history of significant skin disease? Specify.....

Medications used to treat this rash? Specify.....

Known allergies? Specify.....

Provisional diagnosis.....

SECTION B – To be completed by patient

I agree to have a digital photograph taken:

Using a digital camera ☐

Using a smartphone camera ☐

I give permission for the photograph to be:

1. Stored in my medical records, and
2. Shared electronically with other Dermatologists for diagnosis and treatment of my skin problem.

Suggested images

1. Take front, back and side views if the rash is all over the body
2. Use these views to illustrate the worst or most characteristic areas of the rash (E.g. elbows and knees)
3. Detailed close ups of characteristic areas of the rash (I.e. to illustrate redness, pigment loss, scale, Crust, surface detail)

Patient signature.....

Or

Legal Guardian Name.....

Section C-to be completed by the doctor.

Doctor's name.....

If using my own smartphone camera I agree to managing this data securely. All data and images will be held confidentially and only used for clinical care. The patient has the right to object or withdraw consent at any time by advising me of this.

Doctor's signature..... Date.....