

## AFFIX PATIENT LABEL HERE OR COMPLETE

Family name \_\_\_\_\_

First name \_\_\_\_\_

Medicare number \_\_\_\_\_

Postal address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

DOB \_\_\_\_\_ Gender M / F / Other

Tel \_\_\_\_\_

Email \_\_\_\_\_

## REQUESTING PRACTITIONER DETAILS

Doctor's name \_\_\_\_\_

Practice address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel \_\_\_\_\_

Email \_\_\_\_\_

Doctor's signature \_\_\_\_\_

## REQUIRED

- TBP only (standard set of high-resolution body shots)
- TBP Plus (TBP + dermoscopic and clinical imaging)

Online access

A4 prints

CD

Online access

Relevant medical history \_\_\_\_\_

\_\_\_\_\_