PSORIASIS & ECZEMA REFERRAL FORM MATER UNIVERSITY HOSPITAL

Patient Details:

Surname: _____

First Name: _____ DOB: _____

Address: _____

_____

Tel: _____

Hospital Number: _____

Interpreter required: Yes ☐ No ☐

Gender: Male ☐ Female ☐ Wheelchair assistance: Yes ☐ No ☐

General Practitioner Details:

Name: _____

Address: _____

_____

Tel: _____

GP Signature: _____

Date of referral: _____

Medical council registration number: _____

CLINICAL INFORMATION

Psoriasis ☐ Eczema ☐ Other ☐ _____

Body surface area involvement: <10% ☐ 10-30% ☐ 3-50% ☐ >50% ☐ Erythrodermic ☐

Body sites involved: _____

Scalp ☐ Nails ☐ Genital/perianal ☐

Past medical history: _____

_____

HIV ☐ Hepatitis C ☐ Hepatitis B ☐ Immunodeficiency ☐ Malignancy ☐ Sepsis ☐

Medications: _____

Allergies: _____

Hay fever ☐ Food Allergies ☐

Occupation: _____ Alcohol intake (units/week): _____ Smoker: Yes ☐ No ☐

TREATMENT HISTORY

Has this patient attended dermatology previously? No ☐ Mater ☐ Other ☐ _____

Previous Phototherapy ☐ Systemic treatment ☐ _____

Current treatment: _____

Do they have evidence of psoriatic arthritis? Yes ☐ No ☐ **If yes, please attach details of their referral to rheumatology.**

Is this patient's psoriasis/eczema significantly impacting their quality of life? Yes ☐ No ☐

Do you think this patient would benefit from phototherapy? If so, can they commit to attending the Mater 3 times per week for up to 8 weeks?
Yes ☐ No ☐

Would this patient benefit from systemic / biologic treatment? Yes ☐ No ☐

If considering systemic/biologic treatment, please ensure the patient has received the annual flu vaccine, COVID 19 vaccination and pneumococcal vaccine. Females also need to be aware of the need for contraception while on treatment.