ACNE 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: _____

Reason for referral:

- ☐ Moderate acne resistant to antibiotic treatment (more than 3 months of 2 different oral antibiotics)
- ☐ Severe cystic acne
- ☐ Scarring acne
- ☐ Significant psychological distress related to acne
- ☐ Patient >30 years with adult acne resistant to antibiotic treatment
- ☐ Other _____

Previous course of Roaccutane Yes ☐ No ☐

Does the patient have any current or previous psychiatric history? Yes ☐ No ☐

If yes, please give details including diagnosis, current/previous treatment and names of mental health team managing care.

TREATMENT HISTORY

Oral antibiotic <6 weeks ☐ 6-12 weeks ☐ >12 weeks ☐

Lymcycline ☐ Erythromycin ☐ Minocycline ☐ Doxycycline ☐ Trimethoprim ☐ Other _____

Patients require minimum 12 weeks max 6 months of oral antibiotic plus topical retinoid if not C/I

Topical retinoid used: Yes ☐ No ☐

Topical antibiotic used: Yes ☐ No ☐

Past medical history: _____

_____

Comments: _____

FEMALES

On COCP: No ☐ Yes ☐ _____ Date commenced: _____

Other form contraception: No ☐ Yes ☐ _____

Evidence of PCOS ☐

I confirm that:

- ☐ **The patient wishes to be considered for isotretinion treatment**
- ☐ **Baseline bloods have been requested (full blood count, liver function test, urea & electrolytes and fasting lipids and cholesterol)**
- ☐ **Female patients have been counselled regarding the need for reliable and barrier contraception at least 1 month prior to starting treatment, during and at least for 5 weeks following treatment with isotretinion.**