



# Scalp Photography Request Form

## Skin Health Institute

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Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

### Areas to photograph (please tick)

#### Standard views

- Frontal (centre-parted)
- Crown
- Temporal

#### Additional views

- L and R sides
- Forehead
- Occipital

I consent to the above photographs being taken by the medical photographer at the Skin Health Institute for the purpose of aiding in my diagnosis and treatment.

Patient name (printed): \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient address: \_\_\_\_\_

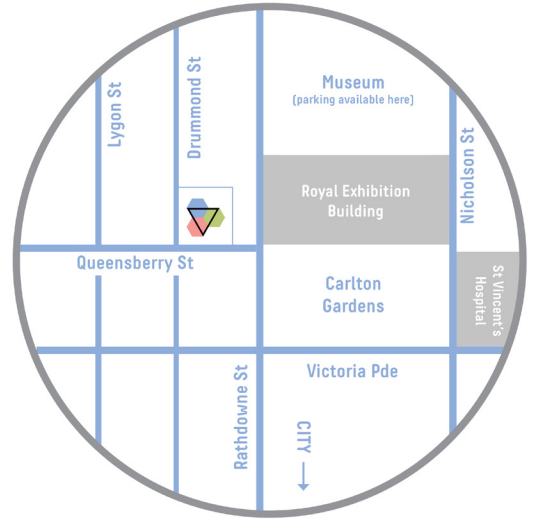
Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

### ATTACH PATIENT LABEL HERE

Surname: .....

UR#: .....



Requesting Doctor: \_\_\_\_\_

Doctor's Practice: \_\_\_\_\_

Practice Contact Number: \_\_\_\_\_

Additional views or notes: \_\_\_\_\_

#### Cost

**\$60** - USB supplied

**\$40** (conc./pension) - USB supplied

Skin Health Institute Patient

Images uploaded to file only

Please note that the cost incurred for medical photography is **NOT** claimable through Medicare.