REFERRING YOUR PATIENT
to the IMAGE TRIAL

IMAGE
Melanoma Surveillance Photography
CLINICAL TRIAL

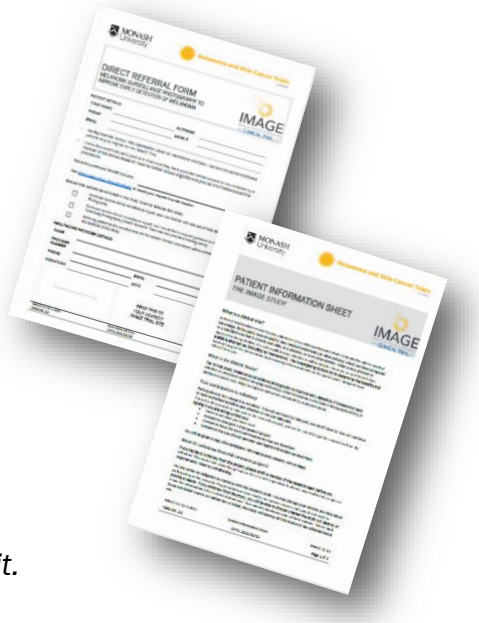
THE IMAGE TRIAL: MELANOMA SURVEILLANCE PHOTOGRAPHY TO IMPROVE EARLY DETECTION OF MELANOMA

1. DISCUSS participation

Discuss whether your patient might be willing to participate in this Monash University sponsored trial and what it means to participate in a clinical trial using the Patient Information Sheet.

2. VISIT the Melanoma and Skin Cancer Trials website

- *Visit www.masc.org.au/recruiting-trials/ (search for 02.19 IMAGE)*
- *Download a Patient Information Sheet*
- *Download a Direct Referral Form*



3. COMPLETE referral form

- *Locate your nearest IMAGE trial site*
- *Send completed referral form to local trial team*

4. IMAGE Research Team will arrange next steps

IMAGE site staff will contact your patient by telephone to answer questions, assess eligibility and arrange a trial visit.

ANY QUESTIONS?

Contact MASC Trials

via image@masc.org.au

DIRECT REFERRAL FORM

MELANOMA SURVEILLANCE PHOTOGRAPHY TO IMPROVE EARLY DETECTION OF MELANOMA

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PATIENT DETAILS:

FIRST NAME		*SURNAME*	
PHONE		*MOBILE*	
EMAIL			

- Having read the IMAGE Trial *Information Sheet For Healthcare Providers*, I believe the abovementioned patient may be eligible for the IMAGE Trial.
- I have discussed trial participation with them and they have provided verbal consent to be contacted by a member of the IMAGE Research Team to further discuss eligibility and provide information about trial procedures.

Patient's preferred IMAGE trial site: _____

Visit www.masc.org.au/recruiting-trials/ to locate your nearest trial site location

Should this patient be enrolled in the trial, I plan to (*please tick one*);

- ☐ Continue routine clinical surveillance myself, and I am familiar with the use of Total Body Photography
- ☐ Continue routine clinical surveillance myself, but I would like to request guidance on the use of Total Body Photography (IMAGE Research Team can also provide a training video).
- ☐ Refer my patient to the selected trial site for routine clinical surveillance with a dermatologist for the duration of the study.

HEALTHCARE PROVIDER DETAILS:

NAME			
PROVIDER NUMBER			
PHONE		*EMAIL*	
SIGNATURE		*DATE*	

Or healthcare provider stamp

SEND THIS TO YOUR NEAREST IMAGE TRIAL SITE