



Patient Name:

DOB:

Referring MD:

Date of Appt.:

Please place a "X" at the location of any lesions and label them accordingly.
 Fax the completed form to Boone Dermatology Clinic at 828-262-3649.

(Circle)

- | | | | | |
|-----------|-----|-----|----------|--------------|
| Lesion 1: | BCC | SCC | Melanoma | Other: _____ |
| Lesion 2: | BCC | SCC | Melanoma | Other: _____ |
| Lesion 3: | BCC | SCC | Melanoma | Other: _____ |
| Lesion 4: | BCC | SCC | Melanoma | Other: _____ |
| Lesion 5: | BCC | SCC | Melanoma | Other: _____ |

