BOONE DERMATOLOGY CLINIC

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: _____