Lucile Packard Children's Hospital AT STANFORD

# GENETIC SKIN DISEASE CENTER CONSULTATION FORM

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|---|---|
| **Patient Name:** | **DOB:** |
| **Patient Phone:** | |
| **Parent's Name:** | |

| | |
|---|---|
| **Referring Physician:** | |
| **Phone:** | **Fax:** |
| **Address:** | |
| **Email (optional):** | |

**Referral to** (please check one of the following):

- ☐ Epidermolysis Bullosa Clinic
- ☐ Vascular Anomalies Clinic
- ☐ Genetic Skin Diseases Clinic

**Reason for consultation:**

Please include any supporting information you may have, such as clinical records, laboratory or pathology data, and imaging study results. Thank you.

**Please fax completed form to (650) 498-4209 Attn: Lisa Taylor, R.N.**

Genetic Skin Disease Center
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