Stanford University School of Medicine
Lucile Packard Children's Hospital at Stanford
Department of Dermatology

Multidisciplinary Clinic
Referral Form

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: Karen Griggs, R.N.

Genetic Skin Disease Center
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