EXCEPTIONAL REFERRAL FORM FOR FACIAL HIRSUTISM

Hospital use only	Clinic	Day/Date	Referring Doctor	Hospital No:

Date:
Patient's Surname:.....
First Names: .....
Address: .....

.....

.....

Post code: .....
Contact telephone no:.....

Date of Birth

CHI Suffix

Practice stamp

Only accept excessive male pattern hair growth(not hairline,eyebrows,upper lip)

(please shade areas of HEAVY DARK TERMINAL HAIR)
(blonde white/ hair does not respond and red has a poor resonse)

Frequency of hair removal:
Method(s) of hair removal currently used:

Results of:

TESTOSTERONE
SHBG
FAI
ANDOSTENEDIONE
DHAS
PROLACTIN
FSH/LH
OESTRADIOL

Diagnosis:

Present medication:

Signature:..... **Name in capitals:** .....

INCOMPLETE FORMS CANNOT BE PROCESSED AND WILL THEREFORE BE RETURNED