RECORD OF COSMETIC CONSULTATION

Patient Name:____ Date:_____________

Reason for Consultation:____

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Cosmetic Diagnosis:____

Recommendations/treatment plan:____

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Contraindications to treatment:____

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Alternatives to treatment discussed:____

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Consultation by:____RN

Reviewed/treatment plan approved by:____MD

Referral to/Reason for referral:____

Address and phone number of practitioner________________________
Name of supervising MD (if applicable)__________________________
Name of medical professional providing services_____________________