NAME: (Last, First)	DATE:
AGE (DOB): SEX: RACE:	MEDS:
ALLERGIES:	
FX SKIN CA OR MM:	
REASON FOR DERM CONSULT: DURATION , SITE, HISTORY:	PRIOR BX:
PMHX:	LABS: (WITH DATES): P7-------|------|-------< CBC >----------< Viral Load: CD4
IMAGES TAKEN (# + SITE) SIGNATURE, PROJECT OUTREACH PROVIDER UPIN# DATE:	

PE:	
ASSESSMENT:	
PLAN: SIGNATURE, UM CONSULTANT UPIN# DATE:	
F/U: UM	PROJECT OUTREACH:
PROJECT OUTREACH TELEDERMATOLOGY CONSULTATION	PATIENT NAME:
	JMH# PROJ OUTR# FINANCIAL CLASS