**About Health Acne Referral**

**Patient Details:**

Name :

NHS No:

Please tick reason/s for referral

* Acne resistant to antibiotics (more than 3 months of oral antibiotics

in combination with topical therapy)

* Severe Nodular-cystic
* Scarring
* Significant psychological upset
* Older patients with long term acne (over 30)
* Other

Please complete the following questions:

* **What treatment is the patient currently using?**
* **Which oral treatments (antibiotic) have been used?**

*Please state if used for over 3 months and if not then why e.g. not tolerated*

* **Current or previous history of depression/** **psychiatric disease?**

**If yes,please provide details below**

* **History of peanut/soya allergy? If yes, please provide details below**
* **What topical treatments have been tried?**
* **BLOOD TESTS**

Please check **FBC, LFT**, **fasting lipids (and a fasting glucose in diabetic patients)** prior to referral and include/forward the results in case the Dermatologist is unable to access the results.

Thank you.

***N.B Consider Referral if Acne has not responded to Oral Antibiotics for at least for 3 months in combination with topical treatment***