



Request For Medical Photography

Patient's Name : Age : Sex :

Nationality : Telephone :

Diagnosis :

Parts of the body to be photographed:

1- 4 -

2- 5 -

3- 6 -

Type of photography:

Color prints Slides Black & white Digital

Further procedures:

1- Clinical meeting Date: 4- Immunology Date:

2- Biopsy Date: 5- Laser Date:

3- Mycology Date: 6- Others

Referring center :

Referring doctor & stamp :

Next Section Will Be Filled By The Medical Photography Unit

	Photos' numbers	Date	Reference number
Color prints			
Slides			
Black & white			
Digital			

Remarks:

Consent - إقرار	
<p>I, Hereby accept to be medically photographed (the parts showing skin disease), according to the treating doctor recommendations. I understand that these photographs will be seen only by the dermatologists in the department and will be used for follow-up of my disease, and for teaching purposes by medical personnel only.</p>	<p>أوافق أنا على تصوير الأجزاء المصابة بالمرض الجلدي والتي يحددها الطبيب المعالج مع علمي بأن هذه الصور هي للاستعمال الطبي ويحتفظ بها داخل القسم ولا يسمح لغير الأطباء الإطلاع عليها وهي لمتابعة الحالة المرضية وللإستخدامات التعليمية والعلمية.</p>
Signature:	التوقيع أو بصمة الإبهام (الأيسر):