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## Nursing Home/Facility Form for Treatment/Visit

(This form must be completed and returned prior to visit)

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Facility: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

POA/Caregiver: \_\_\_\_\_

(must be completed for consent to treat/procedures if patient is unable to sign for self)

Phone: \_\_\_\_\_

Alert and Orientation Status of patient: \_\_\_\_\_

Reason for visit: \_\_\_ LESION \_\_\_ GROWTH \_\_\_ RASH

OTHER: \_\_\_\_\_

Location/Affected area of body:

\_\_\_\_\_

Duration: \_\_\_\_\_

**Symptoms: Please circle all that apply**

asymptomatic / bleeding / catching on clothing / changing color / darkening / enlarging / irregular /  
irritated / itchy / new / not bleeding / not changing size, shape or color / not healing / painful / purulent  
/ recurrent / red / rough and raised / scaly / spreading / stable / swollen / tender

other \_\_\_\_\_

**Previous Treatments:** Prescription and OTC

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_