DERMATOLOGY

Skin lesion assessment

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

LESION HISTORY

Site and laterality

Duration, change and associated symptoms

Prior treatment and relevant risk history

FINDINGS

Location, dimensions and morphology

Examination and dermoscopy findings if performed

Photograph or body-map reference if obtained

ASSESSMENT

Clinical impression and differential

Reasoning for observation, treatment or tissue sampling

PLAN AND PROCEDURES

Options and consent discussion

Procedure details if performed, including site verification and anesthetic used

Specimen label, destination and requested test if collected

Aftercare and result communication plan

Clinician responsible for reviewing results

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding