

# Fairfax Skindeep Tattoo Removal Program Physician Notification Form

1. Name of Patient: \_\_\_\_\_
2. Patient address: \_\_\_\_\_  
\_\_\_\_\_
3. Patient Telephone: \_\_\_\_\_
4. Date of Birth: \_\_\_\_\_
5. Primary Language: \_\_\_\_\_
6. Name of Parent/Guardian: \_\_\_\_\_
7. Parent/Guardian Address: \_\_\_\_\_  
\_\_\_\_\_
8. Parent/Guardian Telephone: \_\_\_\_\_
9. Family Physician: \_\_\_\_\_
10. Case Manager Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
11. Location of Tattoo(s) (circle): face, neck, fingers, hands, forearms, other: \_\_\_\_\_

**NOTE: This form is to be completed by Skindeep Interagency Committee and faxed to ASPRS prior to patient appointment.**