Dermaroller™

Procedure Patient Record

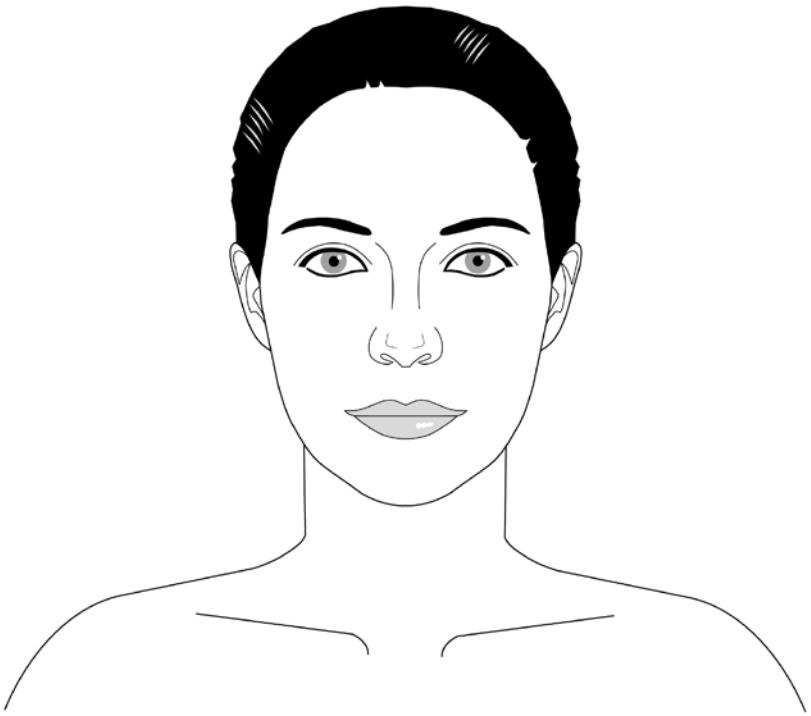
Patient Name: _____ Patient Number: _____

Phone Number Home: _____ Date of Birth: _____

Work: _____ Age: _____ Years

Mobile: _____ Sex: MALE/FEMALE (please delete)

Skin conditions being treated	Locations



Procedure No.	Date of Procedure	Model & lot/batch no. of Dermaroller™	Photo		Anaesthesia type & amount	Assessed improvement*	Comments
			Before	After			

*When compared to condition prior to course of Dermaroller™ procedures

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