

TBSA Map Form

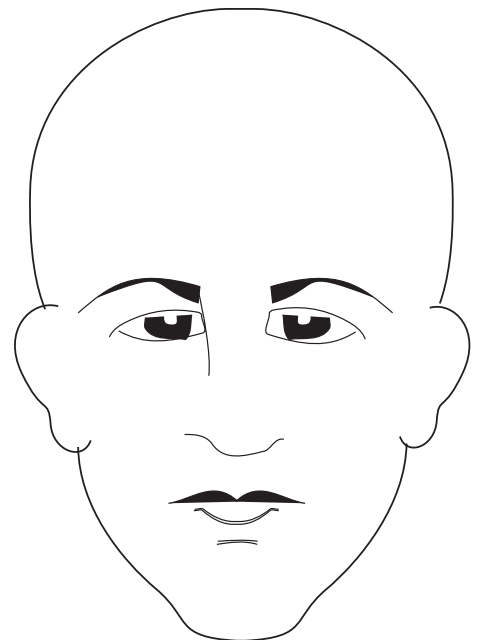
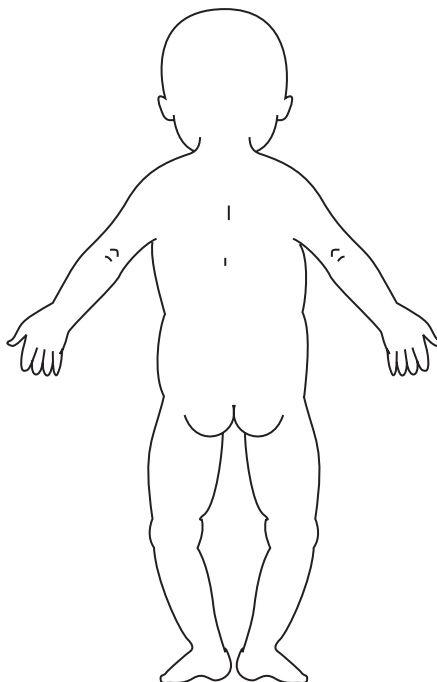
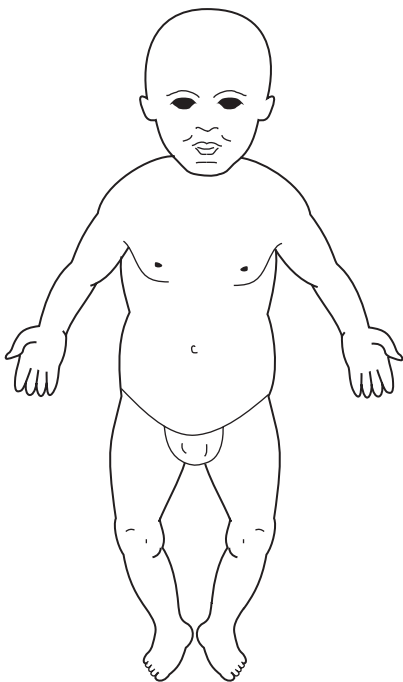
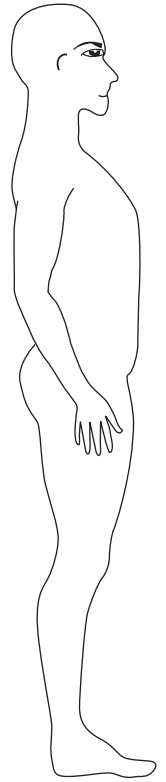
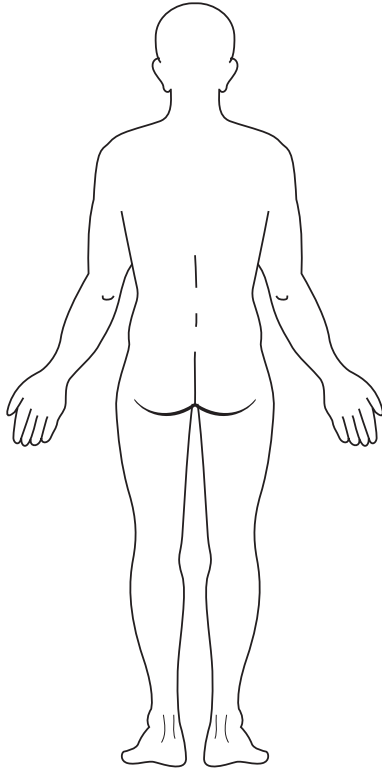
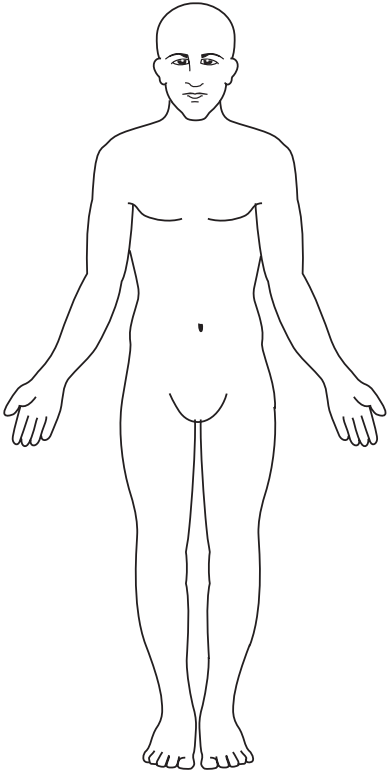
Patient details
(Please print in black
with CAPITAL letters)



Last name

First name

Date DD/MM/YYYY



Email, fax or return forms to:

Unit 1, Level 1, 100 Station Street
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T 1800 772 577
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