

REFERRING YOUR PATIENT to the *IMAGE TRIAL*



THE IMAGE TRIAL: MELANOMA SURVEILLANCE PHOTOGRAPHY TO IMPROVE EARLY DETECTION OF MELANOMA

1. **DISCUSS participation**

Discuss whether your patient might be willing to participate in this Monash University sponsored trial and what it means to participate in a clinical trial using the Patient Information Sheet.

2. **VISIT the Melanoma and Skin Cancer Trials website**

- Visit www.masc.org.au/recruitingtrials/ (search for 02.19 IMAGE)
- Download a Patient Information Sheet
- Download a Direct Referral Form

3. **COMPLETE referral form**

- Locate your nearest IMAGE trial site
- Send completed referral form to local trial team

4. **IMAGE Research Team will arrange next steps**

IMAGE site staff will contact your patient by telephone to answer questions, assess eligibility and arrange a trial visit.



ANY QUESTIONS?

Contact MASC Trials
via image@masc.org.au





DIRECT REFERRAL FORM

MELANOMA SURVEILLANCE PHOTOGRAPHY TO IMPROVE EARLY DETECTION OF MELANOMA

**PATIENT DETAILS:**

FIRST NAME _____ **SURNAME** _____
PHONE _____ **MOBILE** _____
EMAIL _____

- Having read the IMAGE Trial *Information Sheet For Healthcare Providers*, I believe the abovementioned patient may be eligible for the IMAGE Trial.
- I have discussed trial participation with them and they have provided verbal consent to be contacted by a member of the IMAGE Research Team to further discuss eligibility and provide information about trial procedures.

Patient's preferred IMAGE trial site: _____

Visit www.masc.org.au/recruitingtrials/ to locate your nearest trial site location

Should this patient be enrolled in the trial, I plan to (*please tick one*);

- Continue routine clinical surveillance myself, and I am familiar with the use of Total Body Photography
- Continue routine clinical surveillance myself, but I would like to request guidance on the use of Total Body Photography (IMAGE Research Team can also provide a training video).
- Refer my patient to the selected trial site for routine clinical surveillance with a dermatologist for the duration of the study.

HEALTHCARE PROVIDER DETAILS:

NAME _____
PROVIDER NUMBER _____
PHONE _____ **EMAIL** _____
SIGNATURE _____ **DATE** _____

Or healthcare provider stamp

**SEND THIS TO
YOUR NEAREST
IMAGE TRIAL SITE**

