WORD DERMATOLOGY

Physician Referral Form

We welcome patient referrals from all providers and specialties. Please fax this form, pertinent clinic notes, laboratory report(s), and/or pathology report(s), along with insurance information.

FAX: (972) 736-3375

Date of Request:_____

Request: • Surgery • Consultation

Reason for Referral (check one or more, indicate site if applicable):

- • Acne
- • Allergy
- • Birthmarks
- • Blisters
- • Changing mole
- • Cosmetic
- • Dermatitis
- • Eczema
- • Infection
- • Itching
- • Keratosis
- • Melanoma
- • Mole check
- • Nails
- • Psoriasis
- • Scars
- • Rash
- • Warts
- • FULL BODY DIAGNOSTIC SKIN EXAM
- • Other (not listed):

Patient Name:_____ DOB:_____ • Male • Female

Patient Phone Number(s): ❶ (_____) _____ - _____ ❷ (_____) _____ - _____

Referring Provider: _____

Referring Provider Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Preferred method of communication regarding patient:
- • Phone call to referring physician
- • Letter (Mailed or Faxed)

Thank you

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