

Consultation Request

Requesting Physician/Health Care Professional (HCP) Information: PLEASE PRINT CLEARLY

Date of Request			
Physician/HCP Name	FIRST NAME:	LAST NAME:	NPI#:
Phone Number	()	-	
Fax Number	()	-	
Name of Person Completing Form			

Patient Information: PLEASE PRINT CLEARLY

Patient Name	FIRST NAME:	M.I.:	LAST NAME:
Date of Birth		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Phone Number	()	-	Alt. Number () -
Street Address			
City & State, Zip			
Insurance			
Reason for Consult			
Was a biopsy done?	YES	or	NO (If so, please include pathology, photo or diagram)

If referring for a biopsy proven skin cancer, does the skin cancer require:

- Further treatment (i.e excision, Mohs, etc.) Established Care (skin cancer has already been fully treated)

Check type of appointment needed below. Please include chart notes and insurance card.

- Emergent Urgent Routine Verbal Consult Referral Only
 See today See tomorrow or next business day See within 7 business days Patient is in the referring office at time of scheduling. Forefront Dermatology completes form over the phone. Person calling: _____ Patient is being referred without being seen (referral necessary for insurance)

Please fax to our **Scheduling Concierge at 1-866-698-6884**, we will fax you a confirmation of the appointment date and time. If the patient is in your office and you need immediate service please call our toll free scheduling concierge number at: **1-855-535-7175**

For additional forms or to complete this form **Online** go to **forefrontdermatology.com/physician-referral**