FOREFRONT DERMATOLOGY®
1419 Hamric Drive Oxford, AL 36203
P:256-235-3660

Consultation Request

Office Use Only
Date received: Clerk:

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

Date of Request		
Provider	NAME:	NPI#:
Phone Number		
Fax Number		

Patient Information: **PLEASE PRINT CLEARLY**

Patient Name		
Date of Birth		FEMALE ( ) MALE ( )
Phone Number(s)		
Street Address		
City, State, Zip		
Insurance	*PLEASE SEND COPY OF CARD(S) W/ REFERRAL	

IF PATIENTS INSURANCE REQUIRES INSURANCE AUTHORIZATION PATIENT/ REFERRING PROVIDER ARE RESPONSIBLE FOR MAKING SURE AUTH IS IN PLACE PRIOR TO APPOINTMENT

Reason for Consult	
Has a biopsy been done?	YES ( ) NO ( ) *If yes, please include pathology report, photo, or diagram.

Please fax completed referral sheet, patient demographics, last office note, pathology reports/ labs to: **256-235-3663**. Patient will be contacted to set appointment within 3 business days. We make three attempts to reach each patient. If unable to contact patient we will mail patient a letter and send notice of failure to reach patient back to referring provider.

PLEASE NOTE WE WILL NO LONGER UTILIZE FOREFRONT DERMATOLOGY'S SCHEDULING CONCIERGE SERVICE BEGINNING ON 12/23/24 PLEASE DO NOT FAX REFERRALS TO 866-698-6884 FAX NUMBER ON/ AFTER THIS DATE. PLEASE DISPOSE OF PREVIOUS REFERRAL SHEETS ON/ AFTER 12/23/24.