FOREFRONT DERMATOLOGY®

# 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 | | ☐ Male ☐ 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*
See today

☐ *Urgent*
See tomorrow or next business day

☐ *Routine*
See within 7 business days

☐ *Verbal Consult*
Patient is in the referring office at time of scheduling. Forefront Dermatology completes form over the phone.
Person calling: _____

☐ *Referral Only*
Patient is being referred without being seen (referral necessary for insurance)

**Please fax completed form to (937) 438-9424.**

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 office at: **(937) 438-3376.**