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		Gender:
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.) FAX TO 805-449-4184.** For Assistance in scheduling excision or Mohs ASAP call 805-497-1694, ext. 27404 (M-F 8am-4pm)

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)

FOR EXCISION AND MOHS: Fax to 805-449-4184. For urgent matters call 805-497-1694, ext. 27404

FOR GENERAL DERMATOLOGY CONSULTS: 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