

For Appointments call:

(740) 566-4621 opt. #1

PATIENT REFERRAL/CONSULT

Please fax this form to the appropriate fax number listed above

Please attach a copy of patient's insurance card(s). *** Only accepting Straight Ohio Medicaid Insurance ** Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): Which office would the patient prefer? Please circle preference: Athens		r lease lax this form to the approp	priate lax number listed above.	
Trimary Insurance Cell Phone: Primary Insurance Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): Which office would the patient prefer? Please circle preference:	Patient Name:			DOB://_
Primary Insurance Primary Insurance D* Please attach a copy of patient's insurance card(s). ** Only accepting Straight Ohio Medicaid Insurance ** Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): Which office would the patient prefer? Please circle preference: Athens Belpre Chillicothe Lancaster	ddress:			
Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): Which office would the patient prefer? Please circle preference: Athens F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 Rock Hill F: 803-659-3672 F: 740-313-4023 F: 937-505-6506 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Circle Preference: Physician Only F: 803-659-3672 F: 803-6	Iome Phone:		Cell Phone:	
Please attach a copy of patient's insurance card(s). ** Only accepting Straight Ohio Medicaid Insurance ** Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): Which office would the patient prefer? Please circle preference: Athens	rimary Insurance*:		Primary Insurance ID*:	
*** Only accepting Straight Ohio Medicaid Insurance ** **Primary Diagnosis/Complaint (Include any information that pertains to your patient's current issue): **Which office would the patient prefer? Please circle preference: **Athens** Belpre** Chillicothe** F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 **Rock Hill** Washington Court House* F: 803-659-3672 F: 740-313-4023 F: 937-505-6506 **Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? **Circle Preference:* Physician Only** O'rele Preference:* Emergent - Within 24 to 48 hours if available Urgent - Within 24 to 48 hours if available Please note that the Physician's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	econdary Insurance (if applicable):		Secondary Insurance ID:	
Which office would the patient prefer? Please circle preference: Athens F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 Rock Hill F: 803-659-3672 Washington Court House F: 740-313-4023 F: 937-505-6506 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Physician Only F: Fist Available (Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	Pleas	e attach a copy of pa	tient's insurance co	ard(s).
Which office would the patient prefer? Please circle preference: Athens F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 Rock Hill Washington Court House F: 803-659-3672 F: 740-313-4023 F: 937-505-6506 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Physician Only Or First Available (Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):		** Only accepting Straight O	Ohio Medicaid Insurance **	*
Which office would the patient prefer? Please circle preference: Athens F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 Rock Hill Washington Court House F: 803-659-3672 F: 740-313-4023 F: 937-505-6506 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Physician Only Or First Available (Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	Primary Diagnosis/Complaint (In	clude any information that portain	s to your nationt's current issue	2).
Athens F: 740-566-4622 F: 740-423-3081 F: 740-672-2161 F: 614-908-1340 Rock Hill F: 803-659-3672 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Physician Only or First Available Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):				
F: 740-566-4622 Rock Hill F: 803-659-3672 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Circle Preference: Circle Physician Only Or First Available (Please note that the Physician Assistant's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	Athons			
F: 803-659-3672 Would you prefer your patient to see the Physician Only or may the patient be seen by one of our Dermatology Physician Assistants? Circle Preference: Circle Preference: Physician Only or First Available (Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):				
Physician Only or First Available (Please note that the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):		_		
Circle Preference: Physician Only or First Available (Please note that the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	patient be seen by one of our Dermatology Physician Assistants?		How soon does your patient need to be seen?	
Physician Only or First Available (Please note that the Physician Assistant's schedule.) Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):			Circle Preference:	
(Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.) Routine - Next available Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):	·			
Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue. Referring Physician Signature: Physician Name (please print):				
Referring Physician Signature: Physician Name (please print):				
Physician Name (please print):	••			•
Unono #t	Phone #:	; (picase print)	Fax #:	