OAKVIEW DERMATOLOGY

For Appointments call:

(740) 566-4621 opt. #1

PATIENT REFERRAL/CONSULT

Please fax this form to the appropriate fax number listed above.

Patient Name: _____ DOB: _____/_____/_____

Address: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance*: _____ Primary Insurance ID*: _____

Secondary Insurance (if applicable): _____ Secondary Insurance ID: _____

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**
F: 740-566-4622	**F: 740-423-3081**	**F: 740-672-2161**	**F: 614-908-1340**
◯ **Rock Hill**	◯ **Washington Court House**		◯ **Springfield**
F: 803-659-3672	**F: 740-313-4023**		**F: 937-505-6506**

Would you prefer your patient to see the <u>Physician Only</u> 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.)

How soon does your patient need to be seen?

Circle Preference:

◯ **Emergent** - Within 24 to 48 hours if available

◯ **Urgent** - Within one to two weeks if available

◯ **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): _____

Phone #: _____ **Fax #:** _____

Updated January 2021