

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

F: 740-566-4622

Belpre

F: 740-423-3081

Springfield

F: 937-505-6506

Canal Winchester

F: 614-908-1340

Washington Court House

F: 740-313-4023

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.)

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 #:** _____