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 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

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