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	( )		
Email			
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)

Requested Forefront Dermatology location/provider:

_____

Check type of appointment needed below: **Please include chart notes and insurance card.**

☐ Emergent
Call clinic

☐ Urgent
See within one week

☐ Routine
See within three months

☐ 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