Advanced Dermatology & Skin Cancer Center, PLLC

Referring Physician Consultation Form

Patient Name: ______________________________ Today's Date: ____________________________

Address: __________________________________ DOB: __________________________________

__________________________________ Insurance: ______________________________

SSN: _____________________________________ ID#: __________________ Group#: _________

Patient/Guardian if patient is a minor: Home Phone: ___________________________

____ Mobile: _______________________________

Circle Preference:

- 1st Available
- Lance Henry, MD
- Andrea Thompson, PA-C
- Emily Staggs, APRN, DCNP
- Ryan Crowder, PA-C

Pending diagnosis or reason for referral:

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Has a biopsy been done? Yes No

** If yes, please attach pathology report

Have additional tests been ordered? Yes No

** If yes, please fax results with consult request

Referring Physician

Name: ____ NPI#:_________________________________

Address: ______________________________________ City, State, Zip: ___________________________

Phone: ____ Fax: ___________________________________

HISP address if available: ____

Please fax to 479-966-4979. Include any clinic notes, lab results, pathology results, copy of insurance cards and insurance referral (if needed).

Thank you for allowing us to assist in the care of your patients!