Physician Referral Form

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Diplomate, American Board of Dermatology

We welcome referrals from physicians and providers of all specialties. Please fax this form, pertinent clinic notes, laboratory report(s), and/or pathology report(s), along with insurance information

Fax: (214) 919-3501

Date of request: ___________________

Request: __ Excision __ Consultation Only (*for emergent issues, please call us*)

Patient Name: ___________________________ M: ___ F: ___

DOB: ______/______/______

Patient Phone Number(s): (   ) - ____- _____   (   ) - ____ - _____

Referring Provider: Dr. ____________________________________

Office Phone # _____________________ Office Fax # ________________________

Notes:
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