

CONSULTATION REQUEST FORM

Hello! In order to be in compliance with guidelines for consultations, we are required to receive a *written request* from the referring physician which is clearly documented in the chart. In addition, a copy of this request must be kept in the requesting physician's medical record. Kindly fill out the form below which may be faxed to our office at (828) 262-3649. Please do not hesitate to call if you have any questions or concerns. Our clinic telephone number is (828) 264-4553.

Patient Name: _____

Patient DOB: _____

Dr _____ requests a consultation from Dr _____

for evaluation and potential treatment of a/an _____ (lesion)

on the _____ (location).

Referring Physician's signature

Thank you!
Boone Dermatology Clinic