DERMATOLOGY
Healthcare Excellence

FORM FOR REFERRING PROVIDERS

PATIENT INFORMATION

Patient Last Name **Patient First Name** **Patient DOB**

Phone Number **Email Address**

INSURANCE INFORMATION:

Primary Insurance Company **Policy Number** **Group Number**

REASON FOR REFERRAL

Medical/General Dermatology

Diagnosis/Reason: (e.g. psoriasis/rash changing mole/new growth/lupus/etc)

Mohs Surgery

Tumor Type (eg SCC/BCC/etc):
Location:
Biopsy Photo Available? Y N

Excision

Lesion (eg cyst/lipoma/SCC/etc):
Location:

Other:

Details:

REFERRING PROVIDER INFORMATION

Provider Last Name **Provider First Name**

(Check HERE if Dr. Basak already has Provider's cell #)

Direct Provider Cell/Contact Info for MD to MD call. *Please note: Dr. Basak, and ONLY Dr. Basak, will use this number if necessary to clarify or facilitate patient care. If your provider prefers, this info can be emailed directly to Dr. Basak at DrBasak@DHEskincare.com.*

Office Phone Number **Office Fax:** *all office notes, operative reports, and pathology results from DHE will be sent to this fax number*

Please attach or email (info@DHEskincare.com) the following documents:

*Biopsy/Lesion Photo [check HERE if no photo available]
*Pathology Report (if relevant)
*Office Note
*Patient Demographic & Insurance Information