SURGICAL DERMATOLOGY ASSOCIATES, P.A.

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CONSULTATIVE REQUEST

Thank you for your kind request. Please fax this form, pathology report(s), and insurance information to: Fax: (940) 220-6444

Date of request: _____ Request: □ Mohs □ Excision □ Consultation Only

Patient's Name:_____ M: ___ F:___ DOB: _____/_____/_____

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

LESION ID: _____ DX: _____ LOC: _____ SIZE (mm): _____

LESION ID: _____ DX: _____ LOC: _____ SIZE (mm): _____

LESION ID: _____ DX: _____ LOC: _____ SIZE (mm): _____

LESION ID: _____ DX: _____ LOC: _____ SIZE (mm): _____

Referring Provider: _____

Office Phone#:_____ _____ Office Fax#:_____

Notes to SDA:_____

PATIENT INSURANCE INFORMATION

□ ***SEE ATTACHED*** ***(IF ATTACHED, NO NEED TO COMPLETE BELOW)***

PRIMARY:

POLICY:_____
SUBSCRIBER:_____
ID#:_____
GROUP#:_____
PHONE #_____

SECONDARY:

POLICY:_____
SUBSCRIBER:_____
ID#:_____
GROUP#:_____
PHONE#_____

Surgical Dermatology Associates Scheduler Notes:

Consult Required? Y / N Date of □Consult □Surgery: _____/_____/_____ Time:_____

Is the patient traveling over 50 miles to the office? _____

Path Report Received? Y / N Scheduling notes: _____

Revised 1/8/10 SBW