OAKVIEW DERMATOLOGY

For Appointments call:

(740) 566-4621 opt. #1

PATIENT REFERRAL/CONSULT

Please fax this form to the appropriate fax number listed above.

Patient Name: _____ DOB: _____/_____/_____

Address: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance*: _____ Primary Insurance ID*: _____

Secondary Insurance (if applicable): _____ Secondary Insurance ID: _____

Please attach a copy of patient's insurance card(s).

**** Do Not Accept Medicaid HMO Plans ****

Primary Diagnosis/Complaint (*Include any information that pertains to your patient's current issue):*

Which office would the patient prefer? *Please circle preference:*

Athens	Belpre	Chillicothe	Gahanna
F: 740-566-4622	F: 740-423-3081	F: 740-672-2161	F: 614-454-4809

Lancaster	Rock Hill	Springfield
F: 614-908-1340	F: 803-659-3672	F: 937-505-6506

Would you prefer your patient to see the <u>Physician Only</u> or may the patient be seen by one of our Dermatology Physician Assistants?

Circle Preference:

Physician Only or **First Available**

(Please note that the Physician's schedule is normally booked out further than the Physician Assistant's schedule.)

How soon does your patient need to be seen?

Circle Preference:

Emergent - Within 24 to 48 hours if available

Urgent - Within one to two weeks if available

Routine - Next available

Please attach a copy of any exam notes and/or pathology reports relating to the patient's current issue.

Referring Physician Signature: _____

Physician Name (please print): _____

Phone #: _____ **Fax #:** _____

Updated August 2021