**Consultation Request Form**

**Please Complete the Request Form Below and Fax to 315-424-1779**

*Please send any and all pertinent office notes, pathology reports and patient demographic information with the consult request.*

*WE CANNOT SEE PATIENTS FOR ANY SKIN CONDITION RELATED TO WORK INJURIES OR EXPOSURE*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referring Provider Information | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Consult Seeking Provider: | | | | | | | | | | |  | | | | | | | | | | | | | |
| NPI Number: | |  | | | | | | | | | | | | Referral Contact Person: | | | | | | | | |  | |
| Referring Doctors Phone: | | | | | | | |  | | | | | | | | Fax Number: | | | | |  | | | |
| Patient Information | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Name: | | |  | | | | | | | | | | | | | | | DOB: | | |  | | | |
| If < 18 years old, responsible parent or guardians Name: | | | | | | | | | | | | | | | | |  | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: |  | | | | | | | | | | | Alternate Number: | | | | | | |  | | | | | |
| Reason for Referral: | | | |  | | | | | | | | | | | | | | | | | | | | |
| Patient Insurance Information | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Insurance Carrier: | | | | | | | | |  | | | | | | | | | | | | | | | |
| Subscriber Name: | | | | | |  | | | | | | | | | Relation to Patient: | | | | | | | | |  |
| Subscriber ID Number: | | | | | | |  | | | | | | | | | Group Number: | | | | | |  | | |
| Secondary Insurance Carrier | | | | | | | | | |  | | | | | | | | | | | | | | |
| Subscriber Name: | | | | | |  | | | | | | | | | Relation to Patient: | | | | | | | | |  |
| Subscriber ID Number: | | | | | | |  | | | | | | | | Group Number: | | | | | | |  | | |
| Insurance Referral Information | | | | | | | | | | | | | | | | | | | | | | | | |
| Insurance Carrier: | | | | |  | | | | | | | | Referral Number: | | | | | | |  | | | | |
| Effective Date: | | | | |  | | | | | | | | Number of Visits: | | | | | | |  | | | | |