**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*

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| --- |
| 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: |  |