

**DERMATOLOGY REFERRAL FORM**

Date: \_\_\_\_\_

<b>REFERRING PROVIDER INFORMATION</b>	
Referring Provider Name:	
Referring Provider Phone Number:	Fax Number:
Clinic Address:	
<b>PATIENT INFORMATION</b>	
Patient Name:	
Phone Number:	Cell Phone Number:
Street Address:	City, State, Zip:
Date of Birth:	Insurance:
<b>DERMATOLOGY CLINIC LOCATION REQUESTED (circle one)</b>	
Alabama Clinics:	
<ul style="list-style-type: none"> <li><input type="radio"/> Mobile</li> <li><input type="radio"/> Daphne</li> <li><input type="radio"/> Bay Minette</li> </ul>	
Florida Clinics:	
<ul style="list-style-type: none"> <li><input type="radio"/> Miramar Beach (Destin)</li> <li><input type="radio"/> Niceville</li> <li><input type="radio"/> Panama City</li> <li><input type="radio"/> Panama City Beach</li> </ul>	
<b>REFERRAL INFORMATION</b>	
Reason for referral:	
<input type="checkbox"/> Dermatology Issue: _____	
_____	
<input type="checkbox"/> Mohs Surgery Referral: _____	
_____	

*Fax the completed referral form and any clinical notes to:*

- Alabama clinics: 251-631-3572 (fax)
- Florida clinics: 850-266-6301 (fax)

Contact our clinic if any questions at:  
 Toll free: 1-855-693-3763  
 Alabama clinic's main phone: (251) 631-3570  
 Florida clinic's main phone: (850) 502-5989

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