COMMONWEALTH DERMATOLOGY

REFERRAL REQUEST FORM

COMPLETE THIS FORM IN ITS ENTIRETY

(DO NOT MARK WITH "SEE ATTACHMENT")

FAX TO: 804-288-7135

This form should be completed by a healthcare professional familiar with the patient's condition.

We will make every effort to fulfill your request. However, please understand our need to triage the urgency of all requests. Completing this form does not guarantee a patient appointment. Our reviewing staff may make additional recommendations to the referring provider before the patient is seen. No patient will be seen without prior evaluation by the referring provider.
If you would like to talk with a dermatology physician directly about a case, please call 1-804-282-0831.

Today's Date: _____

_____ _____

REFERRING PHYSICIAN NAME **PRACTICE NAME**

_____ _____ _____

Referring Physician Phone Number **Fax Number** **Email**

Please complete **ALL** of the following information below and submit all necessary documentation for the patient's chart.

PATIENT NAME: **PATIENT DOB:**

_____ _____

First Last Month Day Year

If a minor, parent or guardian name: Best contact number:

_____ _____

First Last Area Code Number

Is an interpreter needed? yes no If yes, for which language? _____

INSURANCE NAME: _____ POLICY HOLDER:

_____ _____

Policy Number First Last

PLEASE NOTE: ComDerm does ***NOT*** accept VA Premier, Sentara Medicaid, UHC Community Plan or Cigna Connect
ALL SECTIONS BELOW MUST BE COMPLETED WITH SPECIFIC INFORMATION BEFORE FAXING
Pertinent past medical history:

Onset of symptoms:

Location and description:

Prior treatments and response:

Suspected diagnosis:

Results of prior tests or biopsies (If available, please provide copies of any relevant tests or biopsy reports):

How soon do you need this patient seen? Emergently Urgently Next Available
Please attach a copy of the patient's insurance card (front and back) and demographic information and fax to 804-288-7135.

If patient is a minor, a legal guardian MUST accompany the patient.