CONSULTATION REQUEST FORM

REFERRING PROVIDER INFORMATION		
PRACTICE / PROVIDER		REFERRAL DATE:
OFFICE CONTACT		/ /
CONTACT INFORMATION	STREET ADDRESS: CITY / STATE / ZIP:	PHONE: ( ) - FAX: ( ) - EMAIL:

PATIENT DEMOGRAPHICS		
FULL NAME		DOB: / /
LEGAL GUARDIAN		RELATIONSHIP:
CONTACT INFORMATION	STREET ADDRESS: CITY / STATE / ZIP:	PHONE: ( ) - EMAIL:
INSURANCE		POLICY #:

CLINICAL INFORMATION		
REFERRAL REASON		
SERVICE(S) REQUESTED	☐ ESTABLISH CARE / REFERRAL ONLY (INS REQUIREMENT) ☐ EVALUATION / SECOND OPINION ☐ SPECIFIC SERVICE: ______________________	☐ ROUTINE / 1ST AVAILABLE ☐ URGENT (≤ 1 WEEK) ☐ EMERGENT (≤ 48 HOURS)
ADDITIONAL NOTES		

PLEASE INCLUDE THE FOLLOWING	• PATIENT DEMOGRAPHICS / FACE SHEET • INSURANCE INFORMATION • RELEVANT MEDICAL RECORDS / LABS / DIAGNOSTIC REPORTS

PLEASE SUBMIT COMPLETED FORM & ALL ANCILLARY INFORMATION TO SCHEDULING COORDINATOR
FAX: (769) 768-7547 | EMAIL: referrals@solsticedermatology.com

FOR IMMEDIATE ASSISTANCE CALL: (769) 768-7546

OFFICE USE ONLY – FAX TO REFERRING PROVIDER WHEN COMPLETED		
☐ APPOINTMENT SCHEDULED / PATIENT NOTIFIED	☐ UNABLE TO SCHEDULE	STAFF INITIALS
ON: / / @ : ☐ AM ☐ PM	☐ UNABLE TO CONTACT ☐ PATIENT DECLINED ☐ OTHER: ______________________	__________