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Phone 203-789-1249
Fax 203-776-6188

CONSULTATION REQUEST FORM (updated 9/12/08)

Please make copies to keep on file

Date: _____

Requested Provider: _____

****All attempts will be made to schedule the patient with the requested provider****

Please complete all of the requested information below. Failure to provide us with this important information will delay the scheduling of the appointment. By giving us this information it will allow us to offer more immediate treatment to the most serious conditions. We will contact the patient directly once we have your completed request. All consultations must be initiated by a physician. Patient requested consultations are not valid. We will notify you of your patient's appointment once scheduled.

Patient Name: _____ Phone#1 _____

DOB _____ Phone#2 _____

Address: _____

Insurance name: _____

ID number: _____

Subscriber's name: _____

Does this insurance require a referral? Yes No *(If yes- please have here prior to appointment)*

Requesting Physician:

Name: _____

Address: _____

Phone: _____ Fax: _____

NPI: _____

Diagnosis/Reason for consultation *(use additional sheet to submit additional information if needed):*

Date of 1st symptom for above diagnosis _____

Therapy/Medications *(please include all previous treatment. Attach any biopsy or laboratory reports related to this diagnosis):* _____

Pain/Itching (circle)

None Mild Moderate Severe

Bleeding

None Mild Moderate Severe

Sleeping difficulty

None Mild Moderate Severe

Physician's signature

date