Yale Dermatology-Middlebury
1625 Straits Turnpike~Suite 306
Middlebury, CT 06762
Phone: 203-577-1050
Fax: 203-577-1053

CONSULTATION REQUEST FORM

Date: _____

Requested Provider: _____
****All attempts will be made to schedule the patient with the requested provider****

Please complete all of the requested information below, permitting us to offer more immediate treatment to the most serious conditions. We will contact the patient directly once we have your completed request.

Patient Name:_____

DOB:_____

Phone 1: _____ Phone 2: _____

Address: _____

Insurance name: _____

ID#: _____

Requesting Physician: _____

Address: _____

Phone: _____ Fax: _____

Diagnosis/Reason for consultation:

_____

Date of 1st symptom: _____

Therapy/Medications (Please include treatment history. Attach any biopsy or laboratory reports related to this diagnosis):

_____

Pain / Itching:	None	Mild	Moderate	Severe
Bleeding:	None	Mild	Moderate	Severe
Sleeping Difficulty:	None	Mild	Moderate	Severe

Physician's signature: _____ Date: _____