Yale Dermatology Associates P.C.
2 Church Street South Suite 305
New Haven CT 06519
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**