



REFERRAL FORM

PATIENT INFORMATION - Please complete or attach patient demographics.

First Name:	M.I.	Date of Birth:
Last Name:		Home Phone #:
Street Address:		Cell Phone #:
City:	State:	Zip:

INSURANCE INFORMATION - Please complete or attach copy of insurance card.

Insurance Company:	Group Name or Number:
Subscriber ID #:	Benefits & Eligibility Phone #:
Primary Insured (if not patient):	Date of Birth for Primary Insured:

TREATMENT AREAS

<input type="checkbox"/> Basal Cell Carcinoma	Location(s):
<input type="checkbox"/> Squamous Cell Carcinoma	Location(s):
<input type="checkbox"/> Other:	Location(s):

Is patient aware of diagnosis? YES NO

Does patient have any implants (cochlear, pacemaker, defibrillator)? YES NO

REFERRING PRACTICE

Referring Provider Name:	Practice Name:
Referral Coordinator:	Phone #:

- Pathology Report attached and areas to treat indicated.
- Biopsy Site Photo - Referring provider to email.
*Please email to: photo@caryskincenter.com
- Biopsy Site Photo - Patient to bring to appt. or email to: photo@caryskincenter.com
- Biopsy Site Photo - Cary Skin Center will take photo.
*Please instruct patient to contact us for appt.

CARY SKIN CENTER USE ONLY

Appt. scheduled with: _____
 on: _____ time: _____ am / pm
 Appt. info faxed to referring practice:
 date: _____ by: _____