FRONTIER
DERMATOLOGY

Dermatology and Allergy Consult Request Form

Patient's Name _____

DOB _____/_____/_____ **Patient's Home Phone** _____

Contact Person if other than patient _____

Patient's Insurance Name** _____

Policy No. _____

Reason for visit _____

☐ **URGENT** ☐ **MOHS** ☐ **ROUTINE**

Referring Clinic Information

Provider Requesting Consult _____

Office Phone _____

Office Fax _____

AUTHORIZED SIGNATURE (REQUIRED) _____

Please Check Preferred Location and Fax to Number

☐	Aberdeen	425-970-4565	
☐	Albany	503-362-8435	
☐	Anacortes	360-428-4227	
☐	Arlington	425-939-0807	
☐	Astoria	503-362-8435	
☐	Ballard	503-362-8435	
☐	Beaverton	503-362-8435	
☐	Bellevue	425-646-2965	
☐	Bellingham	425-939-0807	
☐	Centralia	425-970-4565	
☐	Corvallis	503-362-8435	
☐	Coupeville	360-428-4227	
☐	Edmonds	206-525-1169	
☐	Eugene	503-362-8435	
☐	Everett	425-939-0807	
☐	Federal Way	206-859-5776	
☐	Gresham	503-362-8435	
☐	Keizer	503-362-8435	
☐	Laurelhurst	206-525-1169	
☐	Longview	503-362-8435	
☐	McMinnville	503-362-8435	
☐	Mercer Island	206-525-1169	
☐	Mill Creek	425-939-0807	
☐	Monroe	425-939-0807	
☐	Mount Vernon	360-428-4227	
☐	Newport	503-362-8435	
☐	Northgate	206-859-5776	
☐	Olympia	425-970-4565	
☐	Port Angeles	360-994-4975	
☐	Poulsbo	360-994-4975	
☐	Salem	503-362-8435	
☐	Sequim	360-994-4975	
☐	Vancouver	503-362-8435	
☐	Woodburn	503-362-8435	

Along with this form, please fax a copy of patient demographics, copy of insurance card, recent chart notes pertaining to the visit, plus any lab/path reports to the number above.

For Mohs Micrographic Surgery referrals: A pathology report is required and a color photo if available emailed to Mohs.info@frontierdermpartners.com.