



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

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