



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 | ☐ Keizer 503-362-8435 |
| ☐ Albany 503-362-8435 | ☐ Laurelhurst 206-525-1169 |
| ☐ Anacortes 360-428-4227 | ☐ Longview 503-362-8435 |
| ☐ Arlington 425-939-0807 | ☐ McMinnville 503-362-8435 |
| ☐ Astoria 503-362-8435 | ☐ Mercer Island 206-525-1169 |
| ☐ Ballard 503-362-8435 | ☐ Mill Creek 425-939-0807 |
| ☐ Bellevue 425-646-2965 | ☐ Monroe 425-939-0807 |
| ☐ Bellingham 425-939-0807 | ☐ Mount Vernon 360-428-4227 |
| ☐ Centralia 425-970-4565 | ☐ Newport 503-362-8435 |
| ☐ Corvallis 503-362-8435 | ☐ Northgate 206-859-5776 |
| ☐ Coupeville 360-428-4227 | ☐ Olympia 425-970-4565 |
| ☐ Edmonds 206-525-1169 | ☐ Port Angeles 360-994-4975 |
| ☐ Eugene 503-362-8435 | ☐ Portland 503-362-8435 |
| ☐ Everett 425-939-0807 | ☐ Poulsbo 360-994-4975 |
| ☐ Federal Way 206-859-5776 | ☐ Salem 503-362-8435 |
| ☐ Gig Harbor 253-400-1203 | ☐ Sequim 360-994-4975 |
| ☐ Gresham 503-362-8435 | ☐ Vancouver 503-362-8435 |
| ☐ Issaquah 253-839-7166 | ☐ 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.