Bluewater Dermatology
AND SKIN CANCER CENTER, PA

814 Spivey Road Whiteville, NC 28472
tel 910.640.0899 | fax 910.640.2242
www.bluewaterderm.com

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

☐ Basal Cell Carcinoma	Location(s):
☐ Squamous Cell Carcinoma	Location(s):
☐ Other:	Location(s):
Is patient aware of diagnosis? ☐ YES ☐ NO	Does patient have any implants (cochlear, pacemaker, defibrilator)? ☐ 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: **referrals@bdscc.emadirect.md**

Bluewater Dermatology Use Only

Appt. scheduled with:___________________________

on:____________________ time:__________ am / pm

Appt. info faxed to referring practice:

date:__________________ by:__________________

THANK YOU FOR CHOOSING BLUEWATER DERMATOLOGY