

## 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does patient have any implants (cochlear, pacemaker, defibrillator)? <input type="checkbox"/> YES <input type="checkbox"/> NO

### REFERRING PRACTICE

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

<input type="checkbox"/> Pathology Report attached and areas to treat indicated. <input type="checkbox"/> Biopsy Site Photo - Referring provider to email. *Please email to: <b>referrals@bdsc.emadirect.md</b>	<p><b>*Bluewater Dermatology Use Only*</b></p> Appt. scheduled with: _____ on: _____ time: _____ am / pm Appt. info faxed to referring practice: date: _____ by: _____
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