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Consultation Request Form

Please Complete the Request Form Below and Fax to 315-424-1779

Please send any and all pertinent office notes, pathology reports and patient demographic information with the consult request. We will contact the patient and notify you by fax of the appointment time.

WE CANNOT SEE PATIENTS FOR ANY SKIN CONDITION RELATED TO WORK INJURIES OR EXPOSURE

Referring Provider Information			
Name of Provider:			
Referral Contact Person:			
Referring Doctors Phone:		Fax Number:	
Patient Information			
Name:		DOB:	
Gender: Male or Female	If < 18 years old, responsible parent or guardians Name:		
Address:			
Phone Number:		Cell Number:	
Email Address:			
Reason for Referral:			
Patient Insurance Information			
Primary Insurance Carrier:			
Subscriber Name:		Relation to Patient:	
Subscriber ID Number:		Group Number:	
Secondary Insurance Carrier:			
Subscriber Name:		Relation to Patient:	
Subscriber ID Number:		Group Number:	
Insurance Referral Information			
Insurance Carrier:		Referral Number:	
Effective Date:		Number of Visits:	
We need referrals for: SU Pomco, Lifetime 9 Mile, Martins Point, Tricare Prime, Humana HMO			