COMMONWEALTH DERMATOLOGY
REFERRAL REQUEST FORM

COMPLETE THIS FORM IN ITS ENTIRETY
(DO NOT MARK WITH "SEE ATTACHMENT")
FAX TO: 804-288-7135

This form should be completed by a healthcare professional familiar with the patients condition.

Today's Date: _____

Referring physician and practice name:

_____ _____
Name Practice Name

Referring physician phone number and fax number:

_____ _____
Phone Number Fax Number

About the patient:
Please complete **ALL** of the following information below and submit all necessary documentation for the patient's chart.

Patient name: **Patient DOB:**

_____ _____
First Last Month Day Year

If a minor, parent or guardian name: Best contact number:

_____ _____
First Last Area Code Number

Insurance Name:_____ Policy Holder:

_____ _____
Policy Number First Last

PLEASE NOTE: ComDerm does *NOT* accept VA Premier, Optima Medicaid or Cigna Connect
ALL SECTIONS BELOW MUST BE COMPLETED WITH SPECIFIC INFORMATION BEFORE FAXING
Reason for referral:

Location and description:

Prior treatment:

If patient is a minor, a legal guardian MUST accompany the patient.