Georgia Skin and Cancer Clinic

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Dermatology Consultation Request

ATTENTION REFFERRING OFFICES:
PLEASE COMPLETE THE INFORMATION IN THE BOX, SIGN THE REQUEST AND FAX TO 912-629-0379.

Date:_____

Referring Physician/Provider:_____
First Last

Referring Physician/Provider Phone: _____ Fax: _____

Patient: _____ DOB: _____
Last First Middle

Home Phone: _____ Cell: _____

Reason for Referral:

_____

Desired Clinic Location:

Savannah Jesup Brunswick Statesboro South Carolina

Appointment Time Frame:

ASAP Next Available Other_____

PLEASE FORWARD ALL PERTINENT RECORDS/LABS AND INSURANCE DEMOGRAPHICS PRIOR TO THE PATIENT'S APPOINTMENT.

APPOINTMENT: _____
DATE TIME

PROVIDER: _____ **LOCATION:** _____

After third attempt of contacting patient with out success, this referral will be sent back to PCP and kept on file for 30 days.

Georgia Skin and Cancer Clinic Use Only

☐ **Consultation note will be forwarded**

Consultants Remarks:

_____

_____

_____

Provider Signature: _____