



ADVANCED DERMATOLOGY & SKIN CANCER CENTER, PLLC

Referring Physician Consultation Form

Patient Name: _____

Today's Date: _____

Address: _____

DOB: _____

Insurance: _____

SSN: _____

ID#: _____ Group#: _____

Patient/Guardian if patient is a minor:

Home Phone: _____

Mobile: _____

Circle Preference:

- 1st Available
- Lance Henry, MD
- Andrea Thompson, PA-C
- Emily Staggs, APRN, DCNP
- Ryan Crowder, PA-C

Pending diagnosis or reason for referral:

Has a biopsy been done? Yes No

** If yes, please attach pathology report

Have additional tests been ordered? Yes No

** If yes, please fax results with consult request

Referring Physician

Name: _____

NPI#: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

HISP address if available: _____

Please fax to 479-966-4979. Include any clinic notes, lab results, pathology results, copy of insurance cards and insurance referral (if needed).

Thank you for allowing us to assist in the care of your patients!

Toll Free Phone: 1-855-400-9884 **Toll Free Fax:** 1-833-653-8044 **Referral Fax:** 479-966-4979

FAYETTEVILLE
1444 E. Stearns St.
Fayetteville, AR 72703
479-718-7546

BENTONVILLE
701 NW McNelly Rd.
Bentonville, AR 72712
479-268-3555

HARRISON
1320 Hwy. 62/65 N.
Harrison, AR 72601
870-204-5279