TRI-CITY DERMATOLOGY

112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
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PHYSICIAN REFERRAL FORM

(PLEASE PRINT)

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Birth Sex: M_____ F_____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

INSURANCE POLICY INFORMATION

Primary Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group # (if applicable): _____

DIAGNOSTIC INFORMATION

☐ Basal Cell Carcinoma: Location _____

☐ Squamous Cell Carcinoma: Location_____

☐ Melanoma: Location_____

☐ Other: Comments_____

Pathology Report attached: ☐ No ☐ Yes _____

Biopsy Site Photo: ☐ No ☐ Patient will bring to appointment ☐ Referring provider will email to drpeck@tricityderm.com

Is Patient aware of diagnosis? ☐ Yes ☐ No

REFERRING PRACTICE

Referring Provider Name: _____ Practice Name: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____ Fax Number: _____

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Tri-City Dermatology Use ONLY

Appointment scheduled with: _____ Date: _____ Time:_____

Appointment information faxed to referring practice: ☐ Yes ☐ No Date: _____