Referring Doctor: _____

Clinic/Practice: _____

Address: _____

Phone: _____

Fax/Email: _____

Date: ____ / ____ / _____

Dermatologist Specialist Consultation Referral Letter

To: Dermatologist Specialist

Specialty Clinic: _____

Address: _____

Patient Details:
Full Name: _____

Date of Birth: ____ / ____ / _____

Gender: _____

Contact: _____

Reason for Referral:

_____
_____
_____
_____

Relevant Medical History/Findings:

_____
_____
_____

Medications/Allergies:

_____
_____

Additional Notes:

_____
_____

Referring Doctor's Signature:

_____

Name (Printed): _____

Provider Number: _____

Thank you for your attention to this referral.