

DERMATOLOGY CENTER OF
SOUTHERN INDIANA



Leading skin care for over 30 years

Referral Form

Patient Name _____

Date of Birth _____

Referring physician or provider _____

****Attach face sheet or fill in below:**

Address _____

City, State, Zip _____

Phone _____

Insurance _____

Please complete the following:

****Reason for referral (please be as specific as possible)** _____

****Was pathology obtained (if so, please attach)** _____

****Please include last office visit note including current list of medications and problem list**

****Is this referral urgent or non-urgent (examples of urgent referrals include biopsy-proven skin cancer, suspected melanoma, new painful or infectious rash): YES or NO (circle one)**

Additional comments or requests: _____

Fax this form with above requested documents to 812-331-0196.

If your patient does not receive a call from our office within 1 week, please contact us.