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): ☐ Yes ☐ No

**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 ☐ No

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.

1200 S. Rogers Street ● Bloomington, IN 47403 1630 O Street ● Bedford, IN 47421
812.339.6434 (phone) ● 812.331.0196 (fax) ● www.dcsionline.com