Iowa Dermatology Consultants

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Ankeny, IA 50023
P. 515-348-4097

1429 Boston Ave
Ames, IA 50010
P. 515-337-8002

Dermatology Referral Form

This form must be completed by a health care professional

Today's Date: _____

REFERRING PROVIDER

Facility: _____ Name and Specialty: _____

Primary Phone: _____-_____-_____ Fax: _____-_____-_____

PCP (*if different from referring*): _____

PATIENT INFORMATION Gender: M F Prefer not to respond

Name: _____ Date of Birth_____/_____/_____

Contact Name (*if different from patient*): _____

Phone Number _____-_____-_____

Interpreter Needed? Yes No If yes, which language?_____

Insurance carrier: _____

(Please note that Iowa Dermatology Consultant does NOT participate with any Iowa Medicaid Programs through any Managed Care Organizations (MCO) and it will be the responsibility of the patient to contact their insurance carrier to confirm if the organization is in-network)

BACKGROUND

Suspected Diagnosis: _____

Duration of condition: _____ Location: _____

Associated Symptoms: _____

Prior Treatment: _____

Please attach the following (if available) and **fax to 515-257-6977**:
Copy of Patient's Insurance - Relevant Progress Notes - Prior Labs, Tests, and Biopsy Results

*Once **all** documents have been received and reviewed, our office will make at least **three attempts** to contact the patient/guardian to schedule an appointment.*
Thank you for your referral!

Offiice use only:

We have made the following attempts and have been unsuccessful at reaching the patient or the patient has decided not to move forwarded with an appointment and we will no longer make any further attempts. If the provider determines that the patient needs to be seen please have the patient contact our office.

Attempt 1: _____ Attempt 2:_____ Attempt 3: _____