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4bridgesderm.com

FOUR BRIDGES
DERMATOLOGY & COSMETICS

1247 Riverfront Parkway, Suite 205
Chattanooga, TN 37402
Phone: (423) 521-4BDC
Fax: (423) 521-4235

CONSULTATION REQUEST

PATIENT INFORMATION (or attach face sheet)

Patient Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ Email Address: _____

Insurance Company: _____

(Note: Please send a copy of all insurance cards, front and back)

REFERRING CLINICIAN INFORMATION

Referring Clinician: _____

Practice Name: _____

Practice Address: _____

Phone: _____ Fax: _____

NPI #: _____ Direct (HISP) Email: _____

CONSULT INFORMATION (Primary Concern)

- ❑ Nonhealing lesion/sore
- ❑ New/changing pigmented lesion or mole
- ❑ History of skin cancer /screening exam
- ❑ Nonmelanoma skin cancer (BCC/SCC/Other)
- ❑ Melanoma
- ❑ Warts/Molluscum
- ❑ Acute rash (request patient take photos on their phone)
- ❑ Chronic skin condition (eczema, psoriasis, chronic rash)
- ❑ Acne/rosacea
- ❑ Hair loss
- ❑ Other: _____

Pertinent History: _____

_____

_____

_____

❑ **STAT Request** (Please have clinician call 423-521-4232)

❑ **Urgent request** (within 1 week, for symptomatic conditions)

APPOINTMENT INFORMATION

Appointment Date: _____ Appt Time: _____

Physician: **Dr. Brown** **Dr. Cleary** **Dr. Hennings**

*Please encourage your patient to visit our website at ***4bridgesderm.com*** to download all necessary paperwork prior to their appointment.

Practice Direct (HISP) Email Address:

(office use only) Date Consult Note Faxed: _____