WAKE SKIN CANCER CENTER

110 CAPCOM AVE • SUITE 103 • WAKE FOREST, NC 27587 • PHONE: 919-436-4124 • FAX: 919-439-9645

REFERRAL FORM

PATIENT INFORMATION Date:_____

First Name:_____M.I.____Last Name:_____

Address: _____Phone #:_____

City:_____State:_____ Zip:_____

INSURANCE INFORMATION - Please complete or attach attach copy of insurance card.

Insurance Company:_____Group Name or Number:_____

Subscriber ID #: _____ Benefits & Eligibility Phone #: _____

Primary Insured (if not patient):_____ Date of Birth for Primary Insured:_____

TREATMENT AREAS

☐ Basal Cell Carcinoma Location(s):_____

☐ Squamous Cell Carcinoma Location(s):_____

☐ Other Location(s):_____

Is patient aware of diagnosis?

☐ Yes ☐ No

Does patient have any implants (cochlear, pacemaker, defibrilator)?

☐ Yes ☐ No

REFERRING PRACTICE

Referring Provider Name: _____ Practice Name:_____

Referral Coordinator: _____ Phone #:_____

☐ Pathology Report attached and areas to treat indicated.

☐ Biopsy Site Photo - Referring provider to email.
*Please email to:**photos@wakeskincancercenter.com**

☐ Biopsy Site Photo -
*Patient to bring to appt. or email to: **photos@wakeskincancercenter.com**

☐ Biopsy Site Photo – Wake Skin Cancer Center will take photo
*Please instruct patient to contact us for appt.

Wake Skin Cancer Center Use ONLY

Appt. scheduled with:_____on_____time:_____am / pm

Appt. Info faxed to referring practice:

date:_____by:_____