Tennessee River Dermatology
2471 Helton Drive, Florence, AL 35630
Phone: 256.765.2000 ◆ Fax: 256.765.2001 ◆ Email: Referrals@tennriverderm.com

Referring Provider Information

Name: _____ Phone: _____

Address: _____ Fax: _____

City, State, Zip: _____ Email: _____

Patient Information

Name: _____ Phone: _____

Address: _____ DOB:_____

City, State, Zip: _____ Email: _____

Insurance Plan: _____ Policy #: _____

Policy Holder Name: _____ Group #:_____

Primary Care Provider: _____

Referral Information

Has the patient ever been seen in our office? ___Yes ___No

If yes, by which provider? ___Dr. Webb ___Dr. Hanson ___Dr. Thomas ___Ms. Johnson, CRNP

___Rash ___Evaluation and Treatment ___Other: _____

___Skin Cancer (Biopsy Proven) OR ___Suspicious Lesion

Lesion Location: ___Face ___Neck ___Ears ___Scalp ___Other: _____

Is the Lesion: ___Bleeding ___Rapidly Growing ___Scaly/Tender ___Non-healing

Has the lesion been previously (unsuccessfully) treated? ___Yes ___No

Has the patient ever had skin cancer? ___Yes ___No If yes, how many times? _____

TRD OFFICE USE ONLY:

Patient scheduled with: ___Dr. Webb ___Dr. Hanson ___Dr. Thomas ___Ms. Johnson, CRNP

Date: _____ Time: _____ Patient Type: _____

Scheduled By: _____

1st Call Contacted by: _____ Date: _____

2nd Call Contacted by: _____ Date: _____

3rd Call Contacted by: _____ Date: _____