REFERRAL FORM

Dermatology and Skin Cancer Center
3302 Gerig Dr, Ste 100
Bloomington, IL 61704
Phone: (309) 533-7070
2011 Rock St, Ste C
Peru, IL 61354
Phone: (815) 410-4555 *Fax: (855) 710-6552*

Adrienne Schupbach, MD
Board Certified Dermatologist
Board Certified Mohs Surgeon

Douglas Leone, MD
Board Certified Dermatologist
Board Certified Mohs Surgeon

Referral Date:_____ **Return Form to FAX number: (855) 710-6552**

Patient Information:

Patient's Name:_____ Gender: Male Female

Patient's Date of Birth: _____ Responsible Party (if different):_____

Mailing Address: _____ Cell Phone #:_____

_____ Other Phone #:_____

Primary Insurance:_____ ID #:_____

Secondary Insurance:_____ ID #:_____

Consult Diagnosis:_____

_____

Appointment Priority: ☐ First Available ☐ Urgent ☐ Other:_____

Appointment Guidelines:

- We will contact the patient to schedule their appointment, however you can also provide the patient with our phone number so they can call to schedule.
- We are not currently accepting patients with a primary insurance of Medicaid.
- Return completed referral form and corresponding referral paperwork to **(855) 710-6552**

Referring Provider:_____ NPI:_____

Phone #:_____ Fax #:_____ Contact:_____

For Office Use Only

Received Date: _____/_____/_____ *Dates Calls Attempted:*
Scheduled Date: _____/_____/_____ *Notes:*

Thank You for Your Referral!