COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

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Fax Cover Sheet for Referrals (General)

ATTENTION: Referral Coordinator
Email: DermReferrals@coloradodermatology.com
Fax: 303-761-0907
Phone: 303-761-0906

Date: _____

Please refer to Provider:

☐ **Best Fit Based on Clinical Needs** ☐ **First Available** ☐ **Specific Provider:_____**

Referring Clinic: _____

Referring Provider: _____

Sender Phone: _____ Sender Fax: _____

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****Please include a copy of any relevant clinical notes, pathology report, patient demographics, insurance details (including a copy of the front & back of the card(s), if available), and photos****

Patient Name: _____

Patient DOB: _____ Patient Phone Number: _____

Patient Email: _____

Patient Address: _____

City/State/Zip: _____

Patient Insurance Carrier: _____

Insurance Member ID Number: _____

Reason For Visit & Other Notes: _____

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