FAX REFERRAL REQUEST **DATE:_____ Number of Pages:_____**

BOSWELL DERMATOLOGY

Phone: **559.439.3000**|Referral Fax: **559.435-3229**
6730 N West Ave|Fresno, CA 93711|www.boswelldermatology.com

J. Scott Boswell, MD

Jared Lund, MD
Vivian Young, FNP
Jessica Krigbaum, FNP
Brittany Kalajian, FNP
Holly Miller, FNP
Kent Saunders, MD
Jordan Cutts, FNP
Lea Pisching, FNP
Brittney Stanley, FNP
Christina Stempson, FNP
Edgar Botello, FNP

Fax this form to make a referral

Referring Physician: _____ Phone:_____

PCP (if different from referring):_____

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Diagnosis (required): _____

_____

REQUIRED PATIENT INFORMATION

- ☐ Copy of referral
- ☐ Copy of patient insurance card and demographics
- ☐ Copy of last chart notes
- ☐ Copy of pathology report (if applicable)

NOTE: ***All information is needed to schedule an appointment***

Special Instructions: _____

_____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Appointment Date: _____ Time: _____ Contact Person: _____

Board Certified Dermatologists providing:
General Dermatology|Pediatric Dermatology|Adolescent Dermatology|Phototherapy|Mohs Surgery
Thank you for referring your patient to our office.