VALLEY DERMATOLOGY SPECIALISTS

Thank you for choosing to refer your patient to Valley Dermatology Specialist. We sincerely appreciate your trust in our team. To start the referral process, please complete and submit the referral form below.

Requesting Physician/Health Care Professional (HCP) Information: PLEASE PRINT CLEARLY

Date of Request	
Physician/HCP name	
Phone #	
Fax #	
Name of person completing this form	

Patient Information: PLEASE PRINT CLEARLY

Patient	First Name:	M.I:	Last Name:
Date of Birth			
Phone #			
Street Address			
City & State, zip			
Insurance			
Reason for referral/ consult			
Was a biopsy done?	YES or NO		(if so, please include pathology, photo or diagram)

If referring for a biopsy proven skin cancer:

- Does the skin cancer require further treatment (i.e excision, Mohs, etc.):

Please fax the following to (956) 338-5668 or email to referral@valleydermspecialists.com

- Patient's current pertinent information regarding this specific referral diagnosis/reason (office notes etc)
- Patient Demographic Information sheet/ facesheet
- Copy of the front/back of their insurance card.
- Parent/Guardian information (Name/DOB) if the patient is a child (age 0 to 19)