Dermatology
2335 East Kashian Lane, Suite 410
Fresno, CA 93701
559.266.4100
559.266.4199 FAX
InspireHealth.org

FAX REFERRAL REQUEST

Referrals can be made by faxing this form or calling the office.

Date: _____ Number of Pages: _____

- ☐ *First Available Provider*
- ☐ **David Mapes, PA-C**
- ☐ **Sheila Mayo, PA-C, MMSC**
- ☐ **Luis Dehesa, MD**
  General Dermatology and Board Certified Mohs Surgery
- ☐ **Greg Simpson, MD**
  Pediatric & General Dermatology

Referring Physician: _____ Phone: _____

PCP (if different from referring): _____ Phone: _____

Patient Name: _____

Patient Home Phone: _____ Patient Cell: _____

Consultation for: _____

Diagnosis: _____

REQUIRED PATIENT INFORMATION

- ☐ Copy of Referral
- ☐ Copy of Insurance Card and Demographic Sheet
- ☐ Last Chart Notes
- ☐ If referral is for Mohs surgery, please provide:
  - ☐ Anatomical Site(s): _____
  - ☐ Diagnosis/ses: _____
  - ☐ Copy of Pathology Report(s)
  - ☐ FedEx glass slide(s) of biopsy specimen(s)

NOTE: All information is needed to schedule an appointment.

Special Instructions: _____

_____

Contact person: _____ Title: _____

Phone: _____ Fax: _____

Board Certified Dermatologists providing:

General Dermatology ■ Pediatric Dermatology ■ Cosmetic Dermatology

Mohs Micrographic Surgery ■ Dermatologic Surgery ■ Phototherapy

Thank you very much for referring your patient to our office.

* INTERNAL USE ONLY *

Appointment Date: _____ Time: _____ Contact Person: _____