

Please fax this General Dermatology Referral form to 205.930.1750

Date:				
Patient Name:		Patient DOB:	Patient DOB:	
Parent/Legal Guardian (if ap)	plicable):			
Phone Number:	Email Address:			
Mailing Address:				
City:	State:	Zip Code:		
Primary Insurance: Insurance Pro				
Insurance Pro	vider	Policy#	Group #	
Secondary Insurance:	e Provider			
(If applicable) Insurance	Provider	Policy#	Group #	
Reason(s) for Referral/Consu Note: Please indicate either a providers do not see patients	specific provider and/or a loc	cation preference. Please note	that all Total Dermatology	
Provider Request:		Location Request:		
James M. Krell, MD	Heidi Essig, PA-C	Main Office – D	owntown Bham	
Melanie L. Appell, MD	Natalie George, PA-C	C Trussville		
A. Michele Hill, MD	Amber Jackson, PA-0	C Gardendale		
Rajini K. Murthy, MD	Sara Hopper, CRNP	Bessemer		
Stephanie Ives, MD	FIRST AVAILABLI	E FIRST AVAILA	ABLE	
Primary Care Provider:		NPI:	NPI:	
Referring Provider:				
Sent by (person sending form	n):	of pages (including of	cover sheet):	
Referring Office Phone Number:		Fax Number:	Fax Number:	

Please include past clinic notes and all applicable labs with this referral

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