For office use only:
Received by _____ Date _____
Physician _____
Appointment Date & Time _____
New patient appointment letter sent _____
Nurse's notes _____

GREENVILLE HEALTH SYSTEM

Greenville Health System / Carolina Dermatology of Greenville
920 Woodruff Road, Greenville, SC 29607 Phone: 864-233-6338 Fax: 864-235-1982

NEW PATIENT REFERRAL FORM

Patient Information: Date: _____

First, Middle Initial and Last Name _____

Male ☐ Female ☐ Date of Birth: _____ Last 4 digits of SSN: __ __ __ __

Address: _____

Home Phone: _____ Daytime Phone: _____ Email: _____

Race: _____Language: _____ Ethnicity: _____

Needs Interpreter: Yes ☐ No ☐ Language Requested: _____

If Minor, Parent or Guardian Name:_____

Primary Insurance: _____ ID No: _____
Secondary Insurance: _____ ID No: _____
Please send copy of patient's insurance card(s).

Reason for Consult: _____ Dx:_____
Has patient been previously evaluated for these concerns? If so, list treatments tried and failed:
_____

Referring Provider: _____ NPI: _____

Name of Practice: _____

Address: _____

Phone: _____ Fax: _____

Contact Person: _____ Extension: _____

Please Fax this Referral Form, Medical Records including Pathology Reports, and a Copy of Insurance Card(s) to: (864) 235-1982

Thank You for Your Referral
