Referral Form

911 Tech Drive
Ruston, LA 71270
Phone: (318) 265-6376
Fax: (318) 265-6377

3 Medical Plaza Pl
Minden, LA 71055
Phone: (318) 639-4001
Fax: (318) 639-4002

Date: _____

Preferred Location for patient to be seen (Ruston or Minden office) _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Primary Insurance: _____ Secondary Insurance:_____

Referring Provider: _____

Office Phone: _____ Office Fax: _____

Reason for referral: _____

Any other comments: _____

****PLEASE FAX THE FOLLOWING TO THE FAX # ABOVE****

1. **____ This referral form**
2. **____ Front and back of insurance cards**
3. **____ Patient demographic sheet**
4. **____ Pertinent laboratory information, office notes or pathology information (if biopsy done)**

The patient will receive a call with appointment information, and we will let you know the date and time they have been scheduled for their appointment. Thank you for your referral.

Date and time scheduled for Bayou Dermatology appt: _____