BOSWELL DERMATOLOGY

Phone: **559.439.3000** | Referral Fax: **559.435-3229**
5701 N. West Ave | Fresno, CA 93711 | www.boswelldermatology.com

J. Scott Boswell, MD

Jared Lund, MD
Vivian Young, FNP
Kristie Cyrus, FNP
Jessica Krigbaum, FNP
Christina Stempson, FNP
Jordan Cutts, FNP
Lea Pisching, FNP
Brittney Stanley, FNP

Fax this form to make a referral

Referring Physician: ________________________________ Phone:_______________________

PCP (if different from referring):____

Patient Name: ____

Patient Home Phone: _________________________ Patient Cell: ________________________

Diagnosis (required): ____

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REQUIRED PATIENT INFORMATION

- ☐ Copy of referral
- ☐ Copy of patient insurance card and demographics
- ☐ Copy of last chart notes
- ☐ Copy of pathology report (if applicable)

NOTE: ***All information is needed to schedule an appointment***

Special Instructions: ____

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Contact Person: ______________________________ Title: ____________________________

Phone: _____________________________________ Fax: ______________________________

Appointment Date: _______________ Time: ___________ Contact Person: _______________

Board Certified Dermatologist providing:
General Dermatology | Pediatric Dermatology | Adolescent Dermatology | Phototherapy | Dermatologic Surgery
Thank you for referring your patient to our office.