THE University of Vermont MEDICAL CENTER

Dermatology Referral Form

DERMATOLOGY
111 Colchester Ave
Burlington, VT 05401
PHONE: (802) 847-4570
FAX: (802) 847-3364

Patient Name: **Date of Birth:**

Daytime Phone Number:

Interpreter Needed? ☐Yes ☐No **Language:**

Type of Visit: ☐Consult (one time visit) ☐Referral (ongoing care for chronic condition)

Reason (symptoms, ddx, dx):

Time Frame requested for appointment:

☐Emergent (same day, **page** on call MD) – e.g. eruptive rash, blistering rash
☐Urgent (1-3 days) – e.g. **severe** flares of psoriasis, eczema, lupus
☐Semi-urgent (1-3 weeks) – e.g. changing lesion, subacute rash, worsening of chronic issue
☐Within 2-3 months – e.g. chronic rash, unresponsive acne, hair loss
☐Next Available – routine skin checks, cosmetic issues, nail concerns

Treatments tried (please name medications)**:**

Patient Dermatologic History (skin cancer, eczema, atypical moles, F/H of melanoma, etc)**:**

Pertinent Medical History:

Please fill out this form completely and fax along with appropriate clinic notes, pathology reports, and labs to (802) 847-3364, Attn: Scheduling Pool

Appointments will not be given without all information
We will contact the patient with an appropriate appointment. Thank you for your referral.

Office Use Only
Patient scheduled with: _____ on _____ at _____
Scheduled by: _____ on _____