Request for Consultation

Date: ______________________

Referring Physician: ____ Phone: ______________________________

Contact Person: ____ Fax: ________________________________

CHOOSE A LOCATION AND PROVIDER:

Lawrence Dermatology 3511 Clinton Place, Ste. C, Lawrence, KS, 66047, P: 785-331-4488 F: 785-331-4338
☐ First Available ☐ Preference: ____

Leawood Dermatology 11301 Nall Ave., Ste. 205, Inside BMO Harris Bank Bldg, Leawood, KS, 66211, P: 913-451-5934 F: 913-451-4716
☐ First Available ☐ Preference: ____

Shawnee Dermatology & Hair Center 6333 Long Ave., Ste. 360, Inside BMO Harris Bank Bldg, Shawnee, KS, 66216, P: 913-631-6330 F: 913-631-6222
☐ First Available ☐ Preference: ____

Topeka Dermatology 2921 SW Wanamaker Dr., Topeka, KS, 66614, P: 785-272-6860 F: 785-272-5839
☐ First Available ☐ Preference: ____

Manhattan Dermatology 4201B Anderson Ste. 2, Manhattan, KS, 66503, P: 785-320-7774 F: 785-320-7758
☐ First Available ☐ Preference: ____

Legends Dermatology 10940 Parallel Pkwy, Ste. M, Kansas City, KS, 66109, P: 913-788-7099 F: 913-788-7065
☐ First Available ☐ Preference: ____

PATIENT INFORMATION:

Patient's Full Name: ____ Date of Birth: ____________________

Address: ____ City/State/Zip: ____________________________

Primary Phone: ___________________________________ Alternate Phone: __________________________________

Insurance Carrier: ________________________________ Insurance ID: ____________________________________

Policy Holder's Name: ___________________________________ Policy Holder's Birth Date: ____________________

Diagnosis/Symptoms (*please be as specific as possible):* ____

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Biopsy Completed: ☐ Yes ☐ No (*please attach pathology report)* KMC Called: __________________ (date/time)

☐ Patient NOT Scheduled ☐ Patient Scheduled __________________ (date/time)

Special Scheduling Request: ____ OR FIRST AVAILABLE

Fax this form to the appropriate location with any applicable forms including: office notes, x-rays, lab, pathology results, copy of insurance cards, and any scans/special procedures.

FOR KMC OFFICE USE:
Procedure/Consult Date: _________________________________ Time: ____________________________

Faxed to referring physician: ______________________________ Date: ____________________________

Please have patient call appropriate location to reschedule appointments.

Updated: 8/2018