



Request for Consultation

Date: _____

Referring Physician: _____ Phone: _____

Contact Person: _____ Fax: _____

CHOOSE A LOCATION AND PROVIDER:

Emporia Dermatology 1602 W 15th Ave, Ste. D, Emporia, KS 66801 P: 620-208-8518 F: 620-208-8520

First Available Preference: _____

Hunters Ridge Dermatology 3405 NW Hunters Ridge Terr, Ste. 200, Topeka, KS 66618 P: 785-596-1250 F: 785-596-1251

First Available Preference: _____

Independence Dermatology 19101 E Valley View Pkwy, Ste. A, Independence, MO 64055 P: 816-795-3353 F: 816-795-3354

First Available Preference: _____

Kansas City Dermatology 8919 Parallel Pkwy, Ste. 380, Kansas City, KS 66112 P: 913-788-7099 F: 913-788-7065

First Available Preference: _____

Lawrence Dermatology 3511 Clinton Place, Ste. A & C, Lawrence, KS 66047 P: 785-331-4488 F: 785-331-4338

First Available Preference: _____

Leavenworth Dermatology 3550 S 4th St, Ste. 250 (Inside St. John Pavilion), Leavenworth, KS 66048 P: 913-565-2569
F: 913-565-2571

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: _____

Manhattan Dermatology 4201B Anderson Ave, Ste. 2, Manhattan, KS 66503 P: 785-320-7774 F: 785-320-7758

First Available Preference: _____

Mission Dermatology & Hair Center 5820 Lamar Ave, Ste. 200, Mission, KS 66202 P: 913-631-6330 F: 913-631-6222

First Available Preference: _____

Olathe Dermatology 801 N Mur-Len Rd, Ste. 112, Olathe, KS 66062 P: 913-738-8033 F: 913-738-8034

First Available Preference: _____

Topeka Dermatology 2921 SW Wanamaker Dr., Topeka, KS 66614 P: 785-272-6860 F: 785-272-5839

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*): _____



Request for Consultation

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.