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**One-Step Referral Form**

**Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Member Coordinating Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name/Relationship if other than patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Consult for Evaluation and Treatment of:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **BCC/SCC Other** | **Location** | **Clinical Size (cm)** | **Clinically Aggressive? (Y/N)** | **Pre-Op Photo Taken? (Y/N)** |
| **A** |  |  |  |  |  |
| **B** |  |  |  |  |  |
| **C** |  |  |  |  |  |

**Are above lesions close in proximity (<5mm)? (Y/N) Which Sites?** **☐ A** **☐ B** **☐ C**

**( Internal Referral Y/N, Directed Referral Y/N) Name of surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please attach the following:**

☐ Demographic Information ☐ Pathology Report

☐ Insurance Card (if Medicaid with Restricted Access) ☐ Pertinent Dr/Chart Notes

☐ Pre-Op Photo ☐ iTASC Consent and Release

☐ iTASC HiPAA Release ☐ iTASC Media Release

**Confirmation Preference:**

☐ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Call Back \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We will relay appointment confirmation upon scheduling of appointment; To decline, check here** **☐**

**PLEASE FAX THIS REFERRAL FORM TO iTASC ADMIN: 937-345-2351**

***We will contact your patient to schedule an appointment.***

***For additional questions, please contact iTASC admin team at 937-345-2350***

**iTASC USE ONLY**

**APPOINTMENT SCHEDULED**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_**

**APPOINTMENT CONFIRMATION:**

**Fax/Call Back/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_**