Telehealth Referral Request Form

Dermatology Store and Forward Program

Email: hs-telederm@ucdavis.edu or Fax: 916-442-5702

Date/Time Sent to UC Davis Health: _____

From: _____
(Remote Site Telehealth Coordinator)

Clinic Name: _____
Phone: _____
Fax: _____

☐ New Patient: Complete this box and item numbers **1-18 (include front and back copy of insurance card)**

☐ Follow-up: Complete this box and item number 1

Reason for Consult: _____

PATIENT INFORMATION:

1. Patient Name: _____ Date of Birth:_____ ☐ Female ☐ Male
2. Address:_____ City: _____ State: _____ Zip: _____
3. Phone Numbers: Home_____ Work_____
4. Ethnicity _____
5. Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced
6. Have you ever been seen at UC Davis Health under another name? ☐ No ☐ Yes
   If yes, under what name: _____

GUARANTOR INFORMATION: (*Complete this section ONLY if different from patient or if patient is under 18*)

7. Guarantor Name:_____ Date of Birth: _____
8. Address (if different than patient):_____
9. Employer Name: _____Employer Phone:_____

INSURANCE INFORMATION:

10. Name of Insurance:_____ Policy #: _____
11. Authorization #:_____Expiration Date:_____
12. What does the authorization cover and how many visits does it cover?_____

(Please attach copy of insurance card and a copy of insurance authorization.)

POLICY HOLDER INFORMATION: (*Complete this section ONLY if different from patient and Guarantor*)

13. Policy Holder Name:_____ Date of Birth: _____
14. Social Security Number:_____
15. Relationship to Patient:_____

REFERRING PHYSICIAN INFORMATION:

16. First and Last Name:_____Phone: _____
17. Address:_____ City: _____ State: _____ Zip: _____
18. AMA License #: _____

All information requested above is necessary for patient registration. If there are any questions, please call 916-734-7702.