Yale Neurology

A PRACTICE OF THE YALE MEDICAL GROUP
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Yale Skin Biopsy Referral Form

Thank you for your referral. Please fill out this form, and fax back to our office. Please provide the information and documents requested below.

Today's date: _____

Patient Name: _____

Date of Birth: _____

Home Phone: _____ Alternative Phone: _____

Insurance Provider: _____

Reason for Referral: SKIN BIOPSY

Brief Description: _____

_____

EMG completed: Yes / No
If yes, was study normal or abnormal: _____

Is the patient taking Coumadin or on anticoagulation: Yes / No
If yes, patient needs to have INR < 2.0

Referring Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Primary Care Physician Name: _____

Phone: _____ Fax: _____

Address: _____