

Patient Referral Form—Please fax to Boise (208)433-1115 or Fruitland (208)452-7550

Referring Provider/Office: _____ # of pages (w/ cover) _____
RE: Patient: _____ DOB: _____

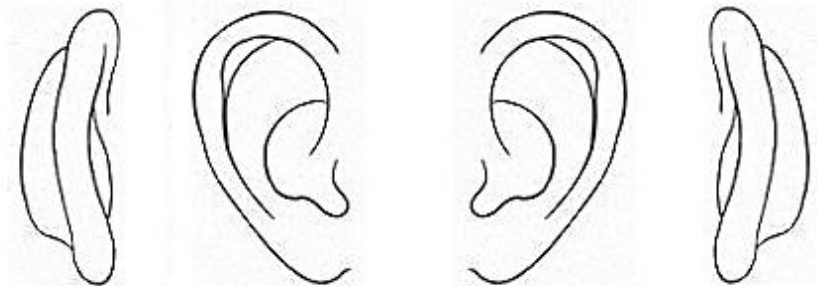
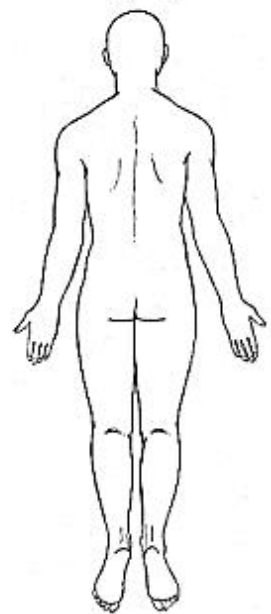
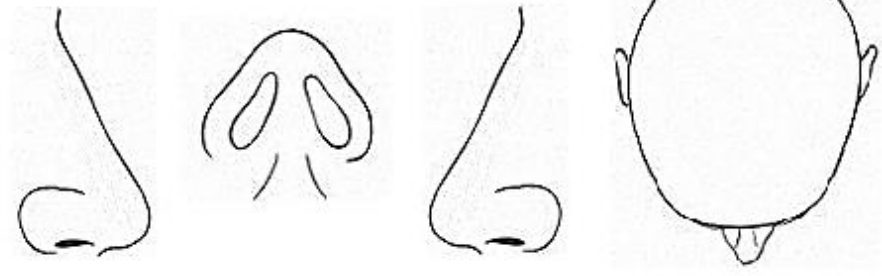
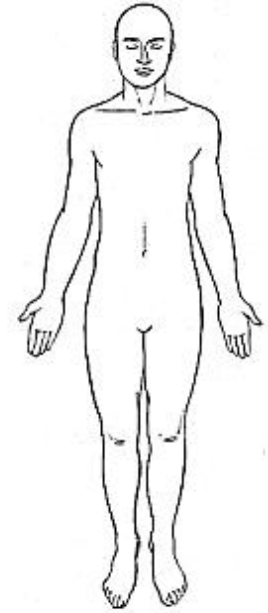
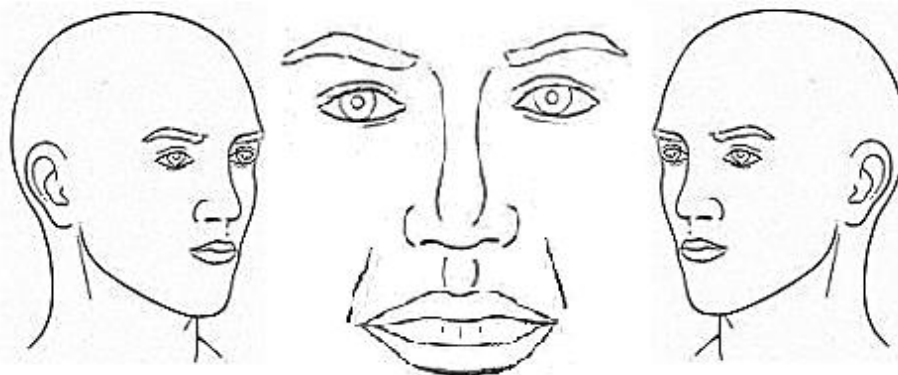
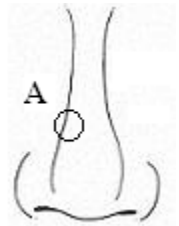
Included: Office notes Pathology Results Patient Demographics

#	Site	Dx	Size
A			
B			
C			

Comments:

Rev. 10/19/2022

Ex:



(back of R ear) (R ear) (L ear) (back of L ear)