University
Dermatology, Inc.

Affiliated entity of
BROWN
Alpert Medical School

BROWN CONTACT DERMATITIS CENTER
REQUEST FOR CONSULTATION AND PATCH TESTING

NAME _____ _____ DOB_____/_____/_____

PATIENT'S DAYTIME PHONE (WITH AREA CODE)_ ( )_____

ALTERNATIVE CONTACT NUMBER (eg CELL) ( )_____

REFERRING M.D._____ PH( )_____FAX_____

CLINICAL INFORMATION

Location(s)_____ Duration_____

Character (*Circle one*) Acute Episodic Chronic Severity_____

Prior treatments:_____

Current treatment_____

Prior patch tests Y N Results?_____

Suspected allergens, occupational exposure_____

Known allergies,
hypersensitivities_____

CHECKLIST OF REQUIRED ITEMS

☐ PRINTOUT OF DEMOGRAPHICS, INSURANCE ENCLOSED

☐ RELEVANT CLINICAL NOTES, BIOPSY, PATCH TEST, LAB RESULTS ATTACHED

☐ FULL PATIENT CONTACT INFO INCLUDING CELL ENCLOSED

PLEASE FAX TO (401)444-7142

QUESTIONS? (401)444-7127(scheduling/nursing)