

**Brown
Dermatology, Inc.**

Affiliated entity of



BROWN
Alpert Medical School

**BROWN CONTACT DERMATITIS CENTER
REQUEST FOR CONSULTATION AND PATCH TESTING**

NAME _____ DOB ____/____/____

PATIENT'S PREFERRED PHONE (WITH AREA CODE) () _____

ALTERNATIVE CONTACT NUMBER () _____

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)