



## UCSF HAIR CLINIC REFERRAL CHECKLIST

1701 Divisadero Street, 4<sup>th</sup> Floor, SF CA 94115, Ph 415-353-7800, Fax 415-353-9654

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Ph: \_\_\_\_\_

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Referring Provider Name: \_\_\_\_\_

Referring Provider Address: \_\_\_\_\_ Ph: \_\_\_\_\_

Fax: \_\_\_\_\_

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**DIAGNOSIS/Differential Dx (CIRCLE ALL that apply):**

• Non-Scarring Hair Loss:

- Androgenetic alopecia/female or male patterned thinning
- Telogen effluvium
- Alopecia areata
- Traction alopecia

- Scarring Hair Loss: (eg. lichen planopilaris, frontal fibrosing alopecia, central centrifugal alopecia, pseudopelade, tufted folliculitis, folliculitis decalvans, dissecting cellulitis)

- Other Diagnosis: \_\_\_\_\_

**PRIOR BIOPSY:** Yes/No? If Yes, please include path report in referral.

**PRIOR LABS:** Yes/No? If Yes, please include lab results in referral.

**PLEASE FAX the following to 415-353-9654:**

**Completed UCSF Hair Clinic Referral Checklist**

**Patient Insurance & Demographic Information**

**Relevant Chart Notes**

**Pathology Report** (\*If non-UCSF pathology, please also submit 1) **UCSF Derspath Requisition Form**, and 2) **Patient Release of Medical Records Form** to facilitate UCSF slide consultation)

**Lab Results**

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