University of California
San Francisco
UCSF
Department of Dermatology

UCSF HAIR CLINIC REFERRAL CHECKLIST

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

Patient Name: _____ DOB: _____

Patient Address: _____ Ph: _____

_____

Referring Provider Name: _____

Referring Provider Address: _____ Ph: _____

_____ Fax: _____

☐ **DIAGNOSIS/DDx (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, folliculitis decalvans, tufted folliculitis, dissecting cellulitis, acne keloidalis)
- 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 Referral Checklist**
- ☐ **Patient Insurance & Demographic Information**
- ☐ **Relevant Chart Notes**
- ☐ **Pathology Report (If non-UCSF pathology, please submit UCSF Dermpath Consultation Form)**
- ☐ **Lab Results**