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/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 Dermpath Requisition Form***, and 2) ***Patient Release of Medical Records Form*** to facilitate UCSF slide consultation)

☐ ***Lab Results***